Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gerald J. Boerner, Sr. 2012 3:20 P January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4616 Lower Beckleysville Road Hampstead Carroll County Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 X M 2 □ F Hours OCt. 24 Country)
Maryland 214-36-7532 1938 Director 73 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Carroll County Hampstead 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 23a (Funeral 4616 Lower Beckleysville Road Page 1 and 2 should be filed within 72 hours after death withment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a 21074 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?

1 X Yes 2 No 1956— If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Divorced 4 Divorced Year or Dates. 960 other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) carpenter construction æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Jacob Boerner Gladys Armacost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan L. Boerner / wife 4616 Lower Beckleysville Road Hampstead, MD 21074 Date 4 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot cemetery, crematory or other place)
St. Paul's Cemetery 1 X Burial 2 Cremation 3 Removal from State Arcadia, Maryland 4 Donation 5 Other (Specify) 2012 21. Signature Funeral Service Licen 22. Name and Address of Facility Eline Funeral Home M 01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a cont Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or imjury Due to (or as a consequence of) Exami burial-transit Cause (Disease or imjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burla Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death Unknown detached the 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 ☐ Yes 2 ☐ No 2 N ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 XNO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) FEB 0 2 2012 egistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01 Richard E. Bentz 2012 M 8:20 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 34 Webster St. Westminster Carroll Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**☐ M 2 ☐ F Director 220-28-3988 78 03/25/1933 MD or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 34 Webster St. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Equipment Operator Carroll County 27 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Allen Bentz Emma K. Strasbourg ____ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Bentz/wife 34 Webster St., Westminster, MD permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition

1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pleasant Valley Cem. 01/21/2012 | Westminster, MD 22. Name and Address of Facilifritts Funeral Home and Chapel, PA 21. Signature of Funeral Service License 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lir Interval Between Immediate Cause (Final Onset and Death all Ph_{_}sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Month Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 \sum Yes 2 No Be 26. Place of Death (Check only one) Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature **JAN 19** Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAN. , 2012 Year ANNE BOREK Μ. 1:00PM 29 Medical 4a Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death VILLAGE AT ROCKVILLE MONTGOMERY ROCKVILLE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 89 1 M 2 XF Days 141 16 3454 Hours JAN. 28, 1923 NEW JERSEY Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits ms 23a or 28a-f s must be notified MD. MONTGOMERY ROCKVILLE 1X Yes 2 □ No 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? 9701- VEIRS DRIVE 20850 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 \(\square\$ No 'n, à Black, White, etc. 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Yes. Give 1 Yes 2 XNo Specify "natural". Completed 3 X Widowed 4 Divorced Specify: WHITE Year or Dates. 1942-45 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the EXECUTIVE 12 INSURANCE Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r and Mental F ည JOSEPH THORNTON ANN MEISLER traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 WALTER BOREK - SON 4833 ALTON PLACE, WASH., DC 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 ₽.E 5 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREM 1/31/12 ALEXANDRIA, VA. Signature of Funeral Service Licenses 22. Name and Address of Facility 2222-WISCONSIN AVE., NW HYSONG CO. WASHINGTON, DC 20007 23a. Part 1. Enter the disease, or complication that caus shock, or heart failure. List only one cause in earlil the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of deliven in the past 12 months?

1 Yes 2 1 46

9 Unknown Month Day Year been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No. 1 Yes **Division of Vital** 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pendina Accident
Suicide
Homicide Investigation M filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DR. 32. Registrare Signature

VETAS

9701

SANDEEP SHARMA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROCKVILLE, MD

1-30-2012

| | | | Please | Type or Print in Black Ir | | • | _ |
|----------------------------|---|------------------------------|---|--|---|---|---|
| | | - | For State | State of Maryland / Depa | artment of Health and I <i>tificate of Death</i> | | 2012 01.501. |
| | | | Registrar 1. Decedent's Name (First, Middle, Las | | IIIICale Oi Dealii | Reg. No. | 3. Time of Death |
| | Physicia Medic | | Nothan, , Brow | _ | | Month Da | |
| | Examin | er | 4a. Facility Name (if not institution, give University of Morphond | street and number) Medical Center | 4b. City, Town, or Location of Death Bothmole | | c. County of Death |
| | Funeral | | 5. Social Security Number 6. Se | | If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | 3altimore 9. Birthplace (State or Foreign |
| | Director | | | M 2 □ F 47 Yrs. | Months Days Hours Min. | (Month, Day, Year) | Y Seaful DE |
| | and Show I at | or | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or Loc | cation | 17,2-73 6 | 10d. Inside City Limits |
| | Maryla 28a-f otifiec | irect | DE Susse | x Seafor | J | | 1 Yes 2 ☐ No |
| | 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | Funeral Director | 10e. Street and Number | 1040 | 10f. Zip Code | 10g. Ci | itizen of What Country? |
| | death v items ier mu | | 11. Marital Status | 12. Was Decedent Ever in U.S. 13. V | Vas Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto | pecify Yes or No- | 14. Race - American Indian, |
| 36 | after call, or xamir | d b | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 No If Yes, Give 1 | Specify: | o nican, etc.) | Black, White, etc. Specify: |
| 21215-0036 | hours natura dical E | Completed | 15. Decedent's E | | lent's Usual Occupation | 16b. k | Gind of Business/Industry |
| 121 | within 72 giene. ier than " ; the Med | mo | Elementary/Secondary (0-12) | | kind of work done during most of wor O NOT use retired) | | 0, 1 |
| | led wit Hygie other ent, th | as l | 17. Father's Name (First, Middle, Last) | 1/62 | taurant Mana | ne/First, Middle, Maiden | Surname |
| ılan | should be filed within 7: and Mental Hygiene. is marked other than aumatic event, the Me | မ | George Bro | um | Ernes | Live Bot | SON |
| Maryland | should and N is ma rauma | | 19a. Informant's Name/Relationship (T) | rpe, Print) 19b. Mailin | g Address (Street and Number or Ru | ral Route Number, City or | r Town, State, Zip Code) |
| | and 2 s Health tem 27 other tra | | Natrina Brown 20a. Method of Disposition | 20b. Place of Dispo | | Pate 20c. L | ocation - City or Town, State |
| Baltimore, | or == or | | 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif | Removal from State cemetery, cren | natory or other place) | | |
| alti | permit. Pa Departmer Important any injury | | 21. Signature of Funeral Service Licens | I Cuctai | Name and Address of Facility 91 7 | <u>-2012 fede</u> 7 W. Isabe | eralsburg, MD |
| | 20 4 4 5 | | Physical | La Faras Fu | <u>ineral Home Sal</u> | isbury, M | ID 21801 |
| | | | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final | 1 | | or respiratory arrest, | Approximate Interval Between Onset and Death |
| | Physician/ Medical | | disease or condition resulting in death) | a. <u>Ischemic Cardion</u> Due to (or as a consequence of): | nyopath y | | Shart and Beatin |
| | Examiner | ٠ | Sequentially list conditions | 6 Gastrointesting 1 | emortage | | |
| | ed sit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence of): |) | | |
| | oe executed ician and burial-transit | | that initiated events resulting in death) Last | c Due to (or as a consequence of): | | | |
| 90 | te be exe nysician he burial | dical | C | d | | | |
| 387 | ertificat ding ph | /Me | IF FEMALE: | 23c. If yes, outcome of pregnancy | | | |
| Box 6876(| attenc attenc I for us | ician | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | 1 Live Birth 2 Fetal death 3 E | Ectopic pregnancy Other (specify) | | 23d. Date of delivery Month Day Year |
| O. B | the de by the tachec | hys | 9 Unknown | 9 Unknown | | | |
| , P.O. | requires that the death certificate been signed by the attending phys should be detached for use as the | Completed by Physician/Medic | Part II. Other significant conditions co | entributing to death but not resulting in the u | nderlying cause given in Part I. | | use contribute to the cause of death? |
| ords | requir been s | letec | | | | | No 3 Probably 4 Unknown |
| Division of Vital Records, | sician: The law r certificate has b director, page 2 s | dmo | | | | 24a. Was an autopsy performed? 1 ☐ Yes 2 🔼 N | 24b. Were autopsy findings available prior to completion of cause of death? |
| al F | ian: Tl artificat ctor, p | Be C | 25. Was case referred to medical examiner? | | 26. Place of Death (Chec | | o 1 Yes 2 No |
| F < | Physic this ce al dire | 유 | 1 Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatien | | ome 5 Residence 6 | S ☐ Other (Specify) |
| n o | ding F th. After | cate: | 27. Manner of Death 1 ★Natural 5 ☐ Pending 2 ☐ Accident Investigation | 28a. Date of injury (Month, Day, Year) 28b. Time of injury | 28c. Injury at work? M 1 ☐ Yes 2 ☐ No | 28d. Describe how injur | y occurred |
| isio | · Atten er dea ector: by the | ertifi | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | | | | d Number or Rural Route Number, |
| Ω | Hospital or Attendi 24 hours after death, Funeral Director: A etely filled in by the fi | al Ce | | | | City or Town, State | |
| | To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the but | Medical Certificate: | (Check 2 L Medical Exami | ician: To the best of my knowledge, death oner: On the basis of examination and/or investible Practitioner: To the best of my knowledge, | igation, in my opinion, death occurred a | at the time, date and place | e, and due to the cause(s) and manner stated. |
| | To the within To the comple | | 29b. Signature and title of certifier | | 29c. License number | 29d. Da | te signed (Month, Day, Year) |
| | m | | M M.O. | | NPI 1093 0 305 | 53 1/2 | 20/2012 |
| | 12. | | 30. Name and address of person who complete Quartucing | ompleted cause of death (Item 23a) (Type, P 22 S. Gleene St. Bo | office man alan | | , |
| | Stat | e | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | barrel | | |
| | Registra | | JAN 30 % | 1012 Down B. A | back | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward E. Brownell Manth 02 Medical **Examiner** 4a. Facility Name (if not institution, give street and numb 4b. City. Town, or Location of Death 4c. County of Death HICOMICO MINSULA KEGINHAL MATICAL SAL156414 Social Security Number 7. Age (In vrs. last birthday) If Under 24 Ars If Under 1 Year Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 136-18-7565 Director 90 1 X M 2 🗆 F 11/19/1921 Vermont or 28a-f show notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits Maryland Wicomico 1 X Yes 2 No Salisbury 10e. Street and Number ō 10f. Zip Code ems 23a or r must be r 10g. Citizen of What Country? Funeral 938 W. Schumaker Manor Drive 21804 USA "natural", or items: and 2 should be filed within 72 hours after death v Health and Mental Hygiene. Iem 27 is marked other than "natural" or itamo 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Navy Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Communication Industrial Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward C. Brownell Freda L. Degenring other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Leimann/daughter 1304 Taney Ave., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 1/27/2012 Salisbury, MD Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyill shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final subwar and Jebszeller Prevenza Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of). cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ctopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? tate has by page 2 s autopsy certificate 1 Yes 2 No 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 Yes 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signatur 29d. Date signed (Month, Day, Year) H50491 12

Registrar

State

100 E. Carroll St., Salisbury, MD 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

Christopher S. Snyder,

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 04506 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Robert Cook 2012 10:17 a^M February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick St. Joseph's Ministries Emmitsburg Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours July nth, Day, 92 215-32-0785 1919 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Keymar Carroll 28a-f Maryland 1 🗌 Yes 2 🕱 No with the 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be by Funeral 23a 21757 6424 Middleburg Road USA iral", or items? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗙 No Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white If Yes Give Completed 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dairy Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dorothy Rider Charles Henry Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6424 Middleburg Road, Keymar, MD 21757 Charlene Bond, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemeta) dephators or other place) 20c. Location - City or Town, State Date Important: If it any injury or c 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 2/4/2012 Ladiesburg, MD Church Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ပ္ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical 1 dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one

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State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

eneces

29d. Date signed (Month, Day, Year)

Rita Harrison MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jahuary Donna M. Claypoole 2012 4:05P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice <u>Towson</u> <u>Baltimore</u> If Under 24 Hrs. 9. Birthplace (State or Foreign Country) PA 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 M 2 Dy (Month, Day, Ye Months Hours 80 220-28-9695 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Carro11 Sykesville and 2 should be filed within 72 hours after death with the 10e. Street and Number 10g. Citizen of What Country? Funeral 2417 Haight Avenue 21784 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 2 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. and Mental Hygiene. is marked other than "natural", If Yes Give White Completed 3 Divorced Specify. Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Engineering Aid Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alvay J. Murray Elizabeth D. Glessner 19a. Informant's Name/Relationship (Type, Print) (Spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Mr. John P. Claypoole, 2417 Haight Ave., Sykesyille, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lake View Mem. Park 1/25/2012 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee Duan M00764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Physician/ Squ amous disease or condition) Medical resulting in death) Examiner Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): the attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ò Month g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has funeral director, page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Spice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 25205 30. Name and address of person who con leted cause of death (Item 23a) (Type, Print) N. Charle St. Balto. Md Z120 701

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN24

2012

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician/ 2012 7:55 PM CHARLES N. CARTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PG CAPITOL HEIGHTS 701 PAINTER COURT 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Social Security Numb Age (In vrs. last birthday **Funeral** 1 💢 M 2 🗆 F 243-54-5645 Director 08-06-1939 Usual Residence of Decedent show 10c. City, Town or Location or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director CAPITOL HEIGHTS 1 X Yes 2 No MD PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 20743 701 PAINTER COURT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: 3 ₩Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 7s Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) DCFD FIREFIGHTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SINA MARTIN ALONZA CARTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 12806 CAMBLETON DR., UPPER MARLBORO, MD 20774 MARIAN WILLIAMS/DAUGHTER 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 2-7-2012 HARMONY MEMORIAL PARK LANDOVER, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 1085 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_, sician/ disease or condition METASTATIC HEAD AND NECK CANCER resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Jo the Funeral Director: After this certificate has been signed by the attending physician and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month for Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🛣 Unknown DEEP VEIN THROMBOSIS Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PULMONARY EMBOLISM page 2 autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 🗶 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 14 Yes Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital: 2 🗆 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 7/2009

State

only one)

29b. Signature and title of certifier

JOCELYNE KOUATCHOU

Jocelyne Koucitchou

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signa

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D6374

M.D. 4041 POWDER MILL ROAD, CALVERTON, MD 20705

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1 Physician/ Margaret Mary Corcoran January 2012 3:35 \mathbf{P} M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BERLIN NURSING AND REHABILITATION CENTER BERLIN WORCESTER 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 146-28-7076 1073071918 93 Director Pennsylvania Usual Residence of Decedent 28a-f show tth and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10218 Old Ocean City Blvd., Unit 8 21811 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry Marqaret (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Receptionist Health Care Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John McGeever Margaret Connery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corcoran Baltimore, M item 27 Michael J. Corcoran/Grandson 14 Brookton Lane, Berlin, MD 21811 and 2 s 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite cemetery, crematory or other place)
Anatomy Gifts 5 1 Burial 2 Cremation 3 Removal from State injury o 4 X Donation 5 ☐ Other (Specify) 2/2/2012 Hanover, MD Registry Signature of Euneral Service Licens 22 Name and Address of Facility HOIIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ orona slase disease or condition resulting in death) Medical Due to (or as a consequence of) years Examiner S Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Yes 2 XNo 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No 1 Yes Yes 2 YN Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 👿 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 **X**No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 🗶 Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifie 29b. Signature A 29c. License number 29d. Date signed (Month, Day, Year) un ao R135131 February 1, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennie Savage, CRNP 9715 Healthway Dr. Berlin, MD 21811 31. Date filed (Month, Day, Year) FEB 0 2 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 18:35PM LIONEL R. CROWNER 01 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince Georges Clinton If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Hours Min (Month. Day, Year) 214-44-4558 Director 1√2 M 2 □ F 65 10-21-1946 Maryland Usual Residence of Decedent show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland notified at Director 28a-f 1 🗆 Yes 2 🔲 No Delaware Sussex Seaford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be Funeral 7533 Station Lane 19973 US items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Examiner Armed Forces? 1 Ves 2 N1 965 Black, White, etc. 1 Never Married Married ō ģ 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 'natural" Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) Hygiene. College (1-4 or 5+) Shipping the Truck Driver Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Ernest Crowner Virgie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Crowner - wife 7533 Station Lane, Seaford, DE 19973 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 Capitol Crematory 02/02/2012

Capitol Crematory 0 2/02/2012 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dover, DE O Box 967 21. Signature of Funeral Se 22. Name and Address of Facility Ch Cranston Funeral Home Seaford, DE19973 anston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner ENTRICULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine INDROF Cause (Disease or injury that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of) attending physician Physician/Medical certificate be P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy the Hospital or Attending Physician: The law requires that the death thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed 2 No 1 Yes 2 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 2012 of death (Item 23a) (Type, Print) 7503 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Olive Leppo Dull February 2012 9:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Golden Living Center of Westminster Westminster Carroll 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex **Funeral** Days (Month, Day, Year) 214-12-1401 Hours Director 1 M 2 XF 92 Dec. 14, 1919 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Carroll Maryland Westminster 10e. Street and Number 10g. Citizen of What Country? Funeral 1234 Washington Rd. 21157 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Force Black, White, etc Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Assembler Shoe Factory other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence A. Leppo Alice Arbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 838 Old Westminster Pike, Westminster, MD 21157 Fay Lockard/Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If if any injury or o Burial 2 Cremation 3 Removal from State Meadow Branch Cem. 02/07/2012 Westminster, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Jule of Funeral Service Doenses Printes Aftererally Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate

Cause (Disease or injury Due to (or as a consequence of). burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use عد كالمبائد Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year ues 2 Unknow Pregnant at time of death Other (specify) a | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy perform Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ္ဝ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Manner of Death 28c. Injury at 28d. Describe how injury occurred s after death. Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29d. Date signed (Mogth, Day, Year) Signa

State Registrar

31. Date filed (Month, Day, Year,

and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

| AMENDED #5 | | HD | Pleas | e Type or Pr | int in | Black | Indeli | ble Inl | k. Ens | ure A | II Copie | s Ar | e Leg | ible. | | |
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| 212-56-1070 BLC 2/2/201 | 2 | For | | State of M | larylan | nd / De | partme | ent of H | Health | and M | lental Hy | /giene | e | | I | 279 1 6 |
| | | State Registrar | | | | С | ertifica | te of L | Death | | | Reg. N | <u>.</u> 21 | 112 | Ula | 510 |
| Physicia | ın/ | 1. Decedent's Name | | | · - | | | | | | 2. Date of De Month | eath | ay 🔾 | Year | 3. Time of I | |
| Medie | cal | | | ley Denn | 1S | | 4b Cit | Town or | r Location | of Death | 01 | 25 | c. County | of Dooth | To: | 45P4 |
| Examir | ıer | Constal | Hospica | 1 11 | 2 (1 | ake | 40.01 | Salis | bur | | | 41 | WIL | | 100 | |
| Funeral | | 5. Social Security Nu | umber 6. | Sex 7. Ag | ge (In yrs. I | last birthda | y) If Und | | If Under Hours | | 8. Date of Bi | rth av. Year) | | | olace (State or | Foreign |
| Director | | 421457-567-1 Usual Residence of | 7 -7 -7 | 1 万M 2 □ F | 60 |) Yrs | | | | | Jan. | | 1952 | | yland | |
| land show dat | 호 | 10a. State | 10b. County | | 10c. Cit | ty, Town or | Location | | | | | | | 1 | 0d. Inside City | y Limits |
| Mary 28a-f otifie | Director | MD | Wicomi | .co | S | alisk | | | | | | | | | 1 🗆 Yes | 2 N No |
| ith the | | 10e. Street and Num | | | | | | Zip Code | | | | _ | itizen of W | Vhat Cour | ntry? | |
| Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral | 132 A Fo | xfield C | ircle, Apt | | S. 1 | | 21801 edent of H | | igin? (Spec | cify Yes or No- | US | | e - Americ | an Indian. | |
| 6 ter de , or its | by F | 1 XNever Marri | ied 2 Married | Armed Forces? | | | | | | | cify Yes or No- Rican, etc.) | | Blac | k, White, | etc. | |
| 1215-0036 thin 72 hours after ane. | ted | 3 Widowed 4 | | If Yes, Give Year or Dates. | | | | | Specify | r: | | | Specify: | Blac | JK. | |
| 72 ho | Completed | | 15. Decedent's cify only highest of | rade completed) | | (G | ecedent's Us ive kind of w e. DO NOT u | ork done o | | st of workir | ng | 16b. l | Kind of Bu | ısiness/In | dustry | |
| within giene. | | Elementary/Seco | | College (1-4 or | 5+) | | orer | 36 (611/60) | | | | Bun | ting | Nurs | sery | |
| rallied and seement and seemen | To Be | 17. Father's Name (F | First, Middle, Last, |) | | | | | | | (First, Middle | | - | | | |
| Maryland S should be filed th and Mental H or Is marked of traumatic ever | - | George W. | | | | _ | | | | | Fran | | | | | |
| Man 2 sho 27 is it | | 19a. Informant's Na Carl Den | | | | | • | | | | Route Number | | | | , | 841 |
| Te and I and I tem item other | | 20a. Method of Disp | osition | | | Place of Di | sposition (N | ame of | | - | ate | | _ocation - | | | 041 |
| Page International Page | | 1 X Burial 2 ☐ 4 ☐ Donation | ☐ Cremation 3 5 ☐ Other (Spec | Removal from State | | | erematory of | | | 0.2/0 | 4/2012 | l Ne | wark | . Mai | rvland | |
| Baltimor permit. Page 1 Department of Important: If it any injury or o | | 21. Signature of Fun | neral Service Lice | nsee | 11 | | 22. Name | and Addres | ss of Facili | ty Sal | isburv | , Ma | rvla | nd | | |
| m 90789 | | Val | well | Cl. All | w | | Jolle | y Men | oria. | 1 Cha | <u>pel – </u> | <u> 1213</u> | Jer | sey I | Road 21 | |
| | | shock, or hear Immediate Cause (F | t failure. List only | nplications that cause one cause on each lin | d the deat e. | . Do not | enter the mo | | 4 | | | | *************************************** | | Approximate Interval Betw Onset and D | /een |
| Physician/ Medical | | disease or condition resulting in death) | | a. CHLO | A consequ | Lence of | DNRY | <u>D</u> | 1/5/2/ | 45R | STAG | 12 | <u> </u> | | | |
| Examiner | | O | 122 | 1- | | | | | | | | | | | | |
| 7 4 | Examiner | Sequentially list cor if any, leading to im cause. Enter Under | mediate lying | Due to (or as | a consequ | uence of): | | | | | | | | | | |
| executed an and rial-trans | xan | Cause (Disease or i that initiated events resulting in death) L | injury | C. Due to (or as | a consequ | uence of: | | | | | | | | \dashv | | |
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| 376(ficate g phys | l edi | | | d | | | | | | | • | | | | | |
| x 68 r certi | Physician/Medical | IF FEMALE: 23b. Was decedent in the past 12 n | | 23c. If yes, outcome | | | 3 🗌 Ectopi | c preananc | CV. | | | - 1 | 23d. Dat | e of delive | ery | |
| Boy death the att | /sici | 1 Yes 2 Unknown | | 4 🗌 Pregnant a 9 🔲 Unknown | at time of o | | 5 Other | | | | | | Mor | nth | Day Ye | ear |
| Division of Vital Records, P.O. Box 68760 rat or Attending Physician: The law requires that the death certificate be executed is affect death. In affector, After this certificate has been signed by the attending physician and all bir by the funeral director, page 2 should be detached for use as the burial-transit | P. | | icant conditions | contributing to death t | out not res | sulting in th | ne underlyin | g cause giv | en in Part | 1. | 23e. Did 1 | tobacco | use contri | ibute to th | ne cause of de | ath? |
| IS, Fuires the sign of the sig | Completed by | | | | | | | | | | 1 🗆 | Yes 2 | No | 3 🗆 Proi | oably 4□ U | Inknown |
| w request special spec | plet | | | | | | | | | | 24a. Was | | 24b. V | Vere auto | osy findings av | vailable |
| Rec The lar | mo | | | | | | | | | | auto perf | ormed? | d | leath? | 2 No | iuse of |
| tal Cian: | Be | 25. Was case referre examiner? | ed to medical | 11 | | | | | ace of Dea | ath (Check | | | | | / | |
| fVj Physi this c | 은 | 1 Yes 2 2 | 1 No | Hospital: 1 Inpat 28a. Date of inju | 7 | ER/Outpa | atient 3 🗆 | | 4 L N | | ne 5 Resi | | | | HOY | 1 CEPS |
| ording rding th. : After e fune | Certificate: | 1 Natural 2 Accident | 5 Pending Investigation | (Month, Da | | injur | | 28c. Injun work 1 \square | | | 8d. Describe | now inju | ry occurre | ea | | |
| iSiC Atter er dez ector by th | ərtifi | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not determined | be 200 Place of Ini | ury - At ho | ome, farm, | street, facto | ory, office | | 2 | | | | r or Rural | Route Numbe | ər, |
| Divital or urs after ral Dir | a C | | _ | building, et | c. (Specify | " | | | | | City or To | wn, State | e) | | | |
| Hosp 24 hou Funer | Medical | (Check | Medical Exar | ysician: To the best of miner: On the basis of a | examination | n and/or in | vestigation, i | n my opinio | on, death or | ccurred at | the time, date | and plac | e, and due | to the cal | use(s) and man | ner stated. |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but | Ž | 29b. Signature and t | | rea Practitioner: To th | ne beet of r | ny Priohlis | | ecurred at t 9c. License | | ate-and plac | ie, and due to | | ate signed | | | |
| | | 1 | par | | | The state of the s | | 50 | 205 | 7111 | , | 0 | 2//2 | 61 | 2 | |
| | シ | 30. Name and addre | ess of person who | completed cause of | death (Item | 1 23a) (Typ | e, Print) | <i>"</i> " | | 041 | | | -/ | 1 | | - |
| Sort | | atters | for (i) | ARY | 10 | ibrec | 173 | 3 51 | tri | BU | RI 1 | ng | 2 2 | 181 | 07 | |
| Sta Registra | | 31. Date filed (Month | 012012 | 32. Registr | ar's Stignat | igran | Kel | | | | Si . | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 19 2012 0700 Ethel Catherine Dixon Jan /Medical 4b. City, Town, or Location of Death 4c. Counfy of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Snow Hill Nursing Home Snow Hill If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 ₩ F 214-32-5473 Director Jan 27, 89 1922 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County r than "natural", or items 23a or 28a-f show the M-dical Examiner must be notified at 1 Yes 2 No MD Worcester Director Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7125 Shockley Road 21863 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, et 1 Never Married 2 Married African-3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 6 Homemaker n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Teamer Dixon, Sr. Martha Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Diane Butler/daughter 405 S. Park Drive, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department Important: if any injury o St. James AME Church 01/28/2012 Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed physician and s the buriaf-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as attending for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lacritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie -2012 (ARAI)

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YTE State

31. Date filed (Month, Day, Year)

Day, Year) 32. R

Market

30. Name and address of person who completed cause of death (Jeem 23a) (Type, Print)



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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 2012 Physician/ 3:17 PM Edgar Eubanks Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Bal firmore University Maryland 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min Director 1 1 M 2 D F 2-23-1965 WASH., DC 46 Yrs 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No MD PRINCE GEORGE HYATTSVILLE ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a U.S.A. 6913 ALLISON STREET 20784 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 ☐XNo Specify. Completed 3 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) YEARS MASONARY ASA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ EDGAR A. EUBANKS WILSON JEAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 6913 ALLISON STREET #D1 ATHENA M. EUBANKS-WIFE HYATTSVILLE, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GLENWOOD CEMETERY 2-7-2012 WASH., DC PINCKNEY-SPANGLER F. H. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 524 - 8TH ST., N. E. WASH., DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line TDo not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Intradodomina Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 18 months Necroti 21rig Dancre Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) sician Physician/Medical Box 68760 attending physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 perform 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital 2 🛚 No ပု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pendina n 24 hours after death.

e Funeral Director: Aft bletely filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completely filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 — Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 31/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore MD

DHMH 17 Rev 06-2011

Registrar

FEB 0 3 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ George Lee Edwards 10 PM Medical 2012 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICOMICO PHINSULA MAINE SALIS6419 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Numbe 9. Birthplace (State or Foreign **Funeral** Days 225-18-3970 89 Months Hours Min. MO06/41/1922 Country) VA **Director** 1 X M 2 🗆 F sidence of Deced show at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director or 28a-f sh notified VA Accomack Onancock 1 🗌 Yes 2 🌂 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 26439 Savageville Rd. 23417 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. Ş 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1943 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Military permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George E. Edwards Tolutha Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jocelyn E. Marshall / Daughter 18394 Dogwood Dr., Onancock, VA 23417 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State Gaskins A.M.E. Cemetery Onancock, VA Donation 5 🗆 Signature of Fune 22. Name and Address of Facility Cooper & Humbles Funeral Co., Inc., Accomac, VA 23301 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Onset and Death Immediate Cause (Final Physician! disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) the be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? certificate has page Yes 2 No 1 Yes 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 DN6 မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA □ Nursing Home 5 □ Residence 6 □ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Time of 28b. Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending nours after death.

neral Director: Af

filled in by the fu Accident Investigation M 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier Notertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the I

complex Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State Registrar 9/6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 5, 2012 Physician/ Joseph August Ferrare 12:30 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Taney town** 4c. County of Death **Examiner** 4038 Baptist Road Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Days (Month, Day, Year) 78 213-30-0528 **Director** 1 X M 2 🗆 F Maryland Dec 23, 1933 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Taneytown Maryland Carroll 1 🗆 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 21787 USA 4038 Baptist Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 Maryland 21215-0036 white 1 Yes 2 No Specify: Korea Yes, Give Specify: 3 XWidowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Nightclub Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Josephine Frilsch Joseph Ferrare 19a. Informant's Name/Relationship (Type, Print)
Vicki Hutton, daughter Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4038 Baptist Road, Taneytown, MD 21787 altimore, 20b. Place of Disposition (Name of Schools Viernatory or other place Carroll Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/7/2012 Winfield, MD SigNature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed after death. the attending physician and ched for use as the burial-transit dause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy been signed by the atter should be detached for u 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director, After this certificate has been six completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗘 🔨 ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

Registrar

DHMH 17 Rev 06-2011

Date filed (Month, Day, Year)

FEB 0 6

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year THOMAS BRADY FOGLE JANUAR' 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Hours 217-32-6766 **Director** 1 M 2 🗆 F 76 May 5, 1935 Maryland or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Emmitsburg Maryland Frederick 1 🗌 Yes 2 🗙 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21727 16521 Tom's Creek Church Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes. Give white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Driver Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ൧ Alva Eyler Harry O. Fogle 19a. Informant's Name/Relationship (Type, Print) ddress (Street and Number or Rural Royte Number, City or Town, State, Zip Code)
Tom's Creek Church Road, Emmitsburg, MD 21727 Mary S. Fogle, wife 20a. Method of Disposition 20c. Location - City or Town, State Date 2010 Blace of Pisposition (Veryla) S 1 X Burial 2 Cremation 3 Removal from State 2/02/2012 Emmitsburg, MD Catholic Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Myers-Durb raw Funeral Home 21. Signature of Funeral Service Licensee 210 W Main St, Emmitsburg, MD 21727 Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Promician/ Chronic myleomonocytic leukemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be Multi organ failure Box 68760 as the I IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown for in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death Yes 2 No detached 9 Unknown P.O. I á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe death? • Hospital or Attending Physician; The 24 hours after death.
• Funeral Director, After this certificate P 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒^No completely filled in by the funeral director, Be 26. Place of Death (Check only one) မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 X Natural 5 Pending Investigation 2 Accider
3 Suicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 1/28/12 MDD 70559 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 W 7th St Donald R Bennett, MD Frederick Md 21701 31. Date filed (Month, Day, Year) 2. Registrar's Signature ack JAN 3 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carolyn Joy Ferguson 2012 6:00 A January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick **Examiner** Mount Airy Lorien Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Jan. 25, Days Hours Illinois 84 1927 553-32-5232 Director 1 □ M 2 🛛 F 28a-f show 10d, Inside City Limits 10b. Count 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notifled at within 72 hours after death with the Maryland Director Maryland | Carroll Mount Airy 1 Yes 2X No 10g. Citizen of What Country? United States 10f. Zip Code Funeral 21771 6601 Christy Acres Circle 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes Completed by 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 X Divorced Year or Dates ntal Hygiene. ted other than "natura s event, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) occupational health nurse nursing permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other It any injury or other traumatic event. The ODGE. and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Mariash Abe Lesser 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ferguson Parks / daughter 6601 Christy Acres Circle Mount Airy, MD 21771 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20, 20c. Location - City or Town, State cemetery, crematory or other place Carroll Cremation 1 Burial 2 X Cremation 3 Removal from State Hampstead, Maryland 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facilify Eline Funeral Home 21. Signature of Funeral Service License 934 South Main Street Hampstead, Maryland 21074 M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phonocany disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exami physician and s the burial-transit resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be up to hours after death. Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) 1 Live Birth
4 Pregnant
9 Unknown Ectopic pregnancy signed by the atter in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown this certificate has been si-ral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 24 hours after users...
Funeral Director. After this certifical funeral director, reserved to by the funeral director, reserved. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) and title of certifier Date signed (Month, Day, Year) 29b. Signat 29c. License numbe npleted cause of death (Item 23a) (Type, Print) d address of person who co 688 POOLE Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene
Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 6:00 P.M Jane E_{-} Furniss 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Bowie 7600 Laurel-Bowie Road 8. Date of Birth (Month, Day, Year) Dec. 27, 1924 Massachusetts 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Days Min. 1 M 2 F Months Hours 87 Director 022-20-7015 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director MD Prince Georges Bowie 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 7600 Laurel-Bowie Road Prince Georges 20715 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify:White 3x Widowed 4 □ Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Butcher Ruth Sinnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fay F. Nash/Daughter 1447 Middleway ,Arnold,MD 21012 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery crematory or other place)
O. Wash. University ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 2012 3). Signature of Funeral Service Licenses 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final accuac Flynician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death the 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2 After this certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: injury t Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined City or Town, State) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c, License number 29d. Date signed (Month, Day, Year) ٥ State Registrar

Registrar

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State

ed (Month, Day, Year)

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2012

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

1415 SDIVISION ST, Suite B

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 JANUARY JEAN WARMAN GUERTLER 8:15 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GLEN MEADOWS HEALTH CARE GLEN ARM BALTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
NEW YORK 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Hours 1 □ M 2 🛛 F 09/18/1916 95 Director 182-05-2086 Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director BALTIMORE 1 Tes 2 X No MD GLEN ARM 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11630 GLEN ARM ROAD 21057 UNITED STATES items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: "natural", Specify: WHITE 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) ELEMENTARY EDUCATION 12 TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ၉ RAY WARMAN ELIZABETH McNEILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN L. GUERTLER / DAUGHTER 820 UNION AVENUE, BALTIMORE, MD 21211 other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CENTER injury or 02/01/2012 4 Donation 5 Other (Specify) STEVENSVILLE, MD 21. Signature of Funer FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 any mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between é Immediate Cause (Final Onset and Death €hysician/ disease or condition Medical resulting in death) ence of): Examiner Sequentially list conditions Examine Due to for es e consequence off if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown Month Day Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has performed certificate 2 🗆 No 1 Yes Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) exammer? 1 Yes Hospital: Other: ပ 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural
2 Accident 5 Pending 24 hours after death Funeral Director: A 01/24/2012 1 Yes 2 No down Investigation UNKNOWAM within 24 hours after death To the Funeral Director; completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number of City or Town, State) 11630 Glen Arm Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Home NUTSING GlenArm Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Deduction Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Detrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29d. Date signed (Month, Day, Year) 2

State Registrar 30. Name and address of person who completed date

1 2012

FEB

te of death (Item 23a) (Type, Print)

6 70 N Charles &

Registrar's Signature

JAN 31, 2012

Ballimore Md 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e Per FH G925 3/22/2012 JH State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 31 JANUARY 3:30 P M CARL OSCAR HAGELIN 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S CENTREVILLE CORSICA HILLS NURSING HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 03/12/1921 MARYLAND 1 X M 2 - F 90 Director 155-16-5395 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director 1 ☐ Yes 2 🌠 No STEVENSVILLE QUEEN ANNE'S MD 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number Funeral UNITED STATES 21666 200 Wineland Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FACILITY MAINTENANCE SUPERVISOR 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည EMMA JOSEPHINE FINK KARL OSKAR HAGELIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 200 WINELAND WAY, STEVENSVILLE, MD 21666 KARL HAGELIN / SON Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER 1 Burial 2 X Cremation 3 Removal from State 02/01/2012 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Pnysician/ disease or condition resulting in death) Medical Examiner Securationly list condition Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Live Birth 2 La reconstant
Pregnant at time of death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year signed by the and be detached for g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been significate has been significated and formed and the second to the s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certife 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

State

Registrar

Day, Year)

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2012

31. Date filed (Month, Day,

back.

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01ga Κ. Hancock 2:10 A M anuar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Future Care Chesapeake Arnold . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 🔯 Months Ohio 88 Director 216-16-9677 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏋 No Maryland | Anne Arundel Arnold 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 21012 440 David Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. <u>Ş</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. WWII 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Manager Sears Roebuck Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Korneluk Dona Varenchuk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Michael Hancock/Son 440 David Drive, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Remqval from State Kalas Crematory 1/31/2012 4 Donation 5 Other (Specify) Edgewater, Maryland ^{22. Name and Address of Facility} George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 of Funeral Service Ligensee 21. Signa al 23a. Part 1. Enter the disease, or composhock, or heart failure. List only one cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate cause on each line Immediate Cause (Final Physician disease or condition resulting in death) mentra Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 일 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 3 2575 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veteran 21108 2012

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marie W. Hellman 18, 2012 8:50 A January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Carroll County Sykesville Transitions Health Care Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan 10, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) 1925 Days 213-20-1830 **Director** 87 Maryland 1 M 2 X F ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. Count Director Sykesville Carroll County Maryland 1 🗶 Yes 2 🗌 No 10f. Zip Code 10g. Citizen of What Country? United States Completed by Funeral 21784 7309 Second Avenue death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Page 1 and 2 should be filed within 72 hours after of ment of Heath and Mental Hygiene.

The 12 is marked other than "natural", or a smart filem 27 is marked other than "natural", or uny or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examinury. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white If Yes. Give 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) real estate realtor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Marie Booker Louis Witzke 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 715 Maiden Choice Lane, Unit PV112 Catonsville, Joseph P. Booker / cousin 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If ite
any injury or of 1 Burial 2 X Cremation 3 Removal from State Jan. 21, Hampstead, Maryland 4 Donation 5 Other (Specify) 2012 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, 21. Signature of Funeral Service Licens Hampstead, Maryland 21074 M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death Yes 2-No signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ▼No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Mursing Home 5 A Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 24 hours after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 18/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Westminster 101 Obir

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day,

Year,

JAN 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 57/5AM 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical burnie 5. Social Security Numbe 050–20–9700 Sex 1 ☐ M 2 🔀 F If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign .1<u>924</u> Hours (Month, Day, Yea 87 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Annapolis Anne Arundel 1 Tes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21409 908 Noah Winfield Terrace Apt. 203 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. White 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Hannah Ernest Blundell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2128 Bay Front Terrace Annapolis, MD 21409 Janet Bielak/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State January Baltimore, MD Metro Crematory, INC 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146

Physician. Medical **Examiner**

nding physician and use as the burial-transi

signed by the a Id be detached for

should page 2

funeral director,

the filled in by

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JAN 2 5 2012

29b. Signature and title of certifier

e Hospital or Attending Physician: The law requires that the death certificate be 1. 24 hours after death. e Funeral Director: After this certificate has been signed by the attending physicia

Division of Vital Records, P.O. Box 68760

Physician/

Examiner

Funeral

Director

28a-f show

ems 23a or 28a-f sh r must be notified a

or items

"natural",

and Mental Hygiene. is marked other than

Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce.

Examiner

the Medical

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical

10a. State

MD

Funeral Director

Completed by

Be

2

Examine Physician/Medical Be ٥ Medical Certificate:

| shock, or heart failure. List only or | ne cause on each line. | | | or respiratory arrest, | | Interval Between Onset and Death |
|---|---|-----------------------------|-----------------------------|-------------------------|-------------------|---|
| disease or condition | 9 | VERMONIT. | t | | | |
| resulting in death) | Due to (or as a consequ | | | | | |
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| that initiated events resulting in death) Last | Due to (or as a consequ | uence of): | | | | |
| resulting in deathy East | 240 10 (01 25 2 05110041 | 401100 017. | | | | |
| | d. | | | | | |
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| IF FEMALE; | 000 16 | | | | | |
| 1230. Was decedent pregnant | 23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta | | regnancy |) | 23d. Date of de | elivery |
| in the past 12 months? | 4 Pregnant at time of a | | | | Month | Day Year |
| 9 Unknown | 9 Unknown | | | | | |
| Part II. Other significant conditions co | entributing to death but not res | culting in the underlying o | auce given in Part I | no- Dista-b | | AL |
| Trait ii. Other signmeant conditions co | intributing to death but not res | sulting in the andenying c | ause given in Fait i. | 23e. Did tobacco | use contribute to | the cause of death? |
| | | | | 1 Tyes | 2 □ No 3 □ F | Probably 4 Onknown |
| | | | | | | |
| .1 | | | | 24a. Was an | 24b. Were au | topsy findings available completion of cause of |
| | | | | autopsy performed? | death? | |
| | | | | 1 🗆 Yes 2 🖼 | No 1 ☐ Ye | s 2 No |
| 25. Was case referred to medical examiner? | | | 26. Place of Death (Che- | ck only one) | | |
| 1 Yes 2 No | Hospital: | ER/Outpatient 3 DO | Other: | | | |
| 27. Manner of Death | 28a. Date of injury | | | lome 5 Residence | | city) |
| 1 Natural 5 Pending | (Month, Day, Year) | injury | 3c. Injury at work? | 28d. Describe how inju | ury occurred | |
| 2 Accident Investigation | | м | 1 Yes 2 No | | | |
| 3 Suicide 6 Could not be | | ome farm street factory | office | 28f. Location (Street a | and Number or Pr | ural Pauta Numbar |
| 4 Homicide determined | building, etc. (Specify | | Onico | City or Town, Sta | | irai rioute Nullibel, |
| 16 | | | | | | |
| 29a Certifier 1 Certifying Phys | ician. To the best of my know | ledge death occured at | the time, date and place, a | and due to the cause(s) | and manner as st | ated |

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

Registrar

State

MUDICAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tsion Berhane,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

| MARLENE RAINES HENRY JANUARY 26, 2012 4b, Eculty, Name (If not institution, give street and number) SUITLAND SUITLAND SUITLAND SUITLAND SUITLAND SUITLAND SUITLAND PRINCE GEORGE'S SUITLAND PRINCE GEORGE'S SUITLAND 100, Citizen of Wheat Country Val When Departed of Present Country To Suiter and Number 100, Country ND PRINCE GEORGE'S SUITLAND 100, Citizen of Wheat Country UN Suiter and Number 100, Citizen of Wheat Country UN Suiter and Number 101, To Code 102, Citizen of Wheat Country UN Suiter and Number 103, Saken 100, Country 104, Race - American Indian, Black, White, etc. Specify colors, Mexican, Purint Rican, etc.) 11, Marias Issue 12, Was Departed of Flees in U.S. 13, Was Departed of Flees in U.S. 14, Race - American Indian, Black, White, etc. Specify Colors, Mexican, Purint Rican, etc.) 15, Specify only hiphest grade completed) 16, Specify only hiphest grade completed) 17, Father's Name (First, Mickide, Last) CARROLL RAINES 18, Mother's Name (First, Mickide, Makaden Sumanne) 190, Mailing Address (Street and Aumber of Hural Route Number. City or Town, State, 2p Code) 190, Mailing Address (Street and Aumber of Puril Route Number. City or Town, State, 2p Code) 190, Mailing Address (Street and Aumber of Puril Route Number. City or Town, State, 2p Code) 190, Mailing Address (Street and Aumber of Puril Route Number. City or Town, State, 2p Code) 190, Mailing Address (Street and Aumber of Puril Route Number. City or Town, State, 2p Code) 190, Mailing Address (Street and Aumber of Puril Route Number. City or Town, State, 2p Code) 190, Mailing Address (Street Aum) | _ | 1 | State Registrar Decedent's Name (First, Middle, Last) | | (| Certificate of | Death | 2. Date of Death | | 3. Time of Death |
|--|--------|--------------|---|--|-----------------------|---|---|---|---|--|
| ## Facility Names of from immunition, they as stated and numbers \$4. Chy, Home is classed on Deals \$2. Chy, Home is classed on Deals \$5. Stated Beauty Names \$7. State | | 1 | | HENRY | | | | Month JANUARY | | |
| 5. Scott Service Number 2.25—3.8—8.5.94 1.5 March 19 Mar | | | a. Facility Name (If not institution, give s | street and number) | | 4b. City, Town, | or Location of Death | 0,111.011 | 4c. County of D | eath |
| Social Security Number 2.5 - 38 - 85.94 1.5 (2.5 m) 2.5 (2.5 m) 2. | mic | | 6310 SKYLINE TERRA | CE | | | | | | |
| Doc. Street and Number Doc. December SUITLAND | | 5 | . Social Security Number 6. Sex 225-38-8594 | X 7. Age | | Months Davs | | 8. Date of Birth (Month, Day, 02–13–19 | Year) | Country) |
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| Security of Information Specific of Programs Specific Specif | 1 | | | ACE | | | 5 | | - | |
| 16a. Decedering is flowed prompting grade completed; 16a. Decedering in Jusual Occupation; 16b. Kind of Business/Industry (Specify) contributing grade completed; 16b. Kind of Business/Industry (School) 17b. Kind of Busine | | | 1 Never Married 2 Married | Armed Forces? | | 77 | | ecify Yes or No- Rican, etc.) | Black, V | Vhite, etc. |
| CARCUL RAINES 19a. Informant's Name-Relationship (Type, Pinnt) GLORIA HOWARD/DAUGHTER CAN Member of Disposition (Name of Comprehence) 19b. Mailing Address (Street and Number or Plural Raule Number. City or Town, State, Zip Code) 6310 SKYLINE TERRACE, SUITLAND, MD 20746 6310 SKYLINE TERRACE, SUITLAND, MD 20746 19b. Mailing Address (Street and Number or Plural Raule Number. City or Town, State or Cemericy, Community or core roles) 19c. Location - City or Town, State or Cemericy, Community or core roles or Cemericy, Community or Cemerics, Community or Cemerics, Community or Cemerics, Community or Cemerics, Cemeri | | | 15. Decedent's Edu | cation | 16a. | (Give kind of work done | during most of work | | 16b. Kind of Busine | ess/Industry |
| CARROL RAINES 19a. Informant's Name-Relationship (Type, Print) GLORIA HOWARD/DAUGHTER 6310 SKYLINE TERRACE, SUTTLAND, MD 2020. Location - City or Town. State, Zip Code) 19b. Mailing Address (Street and Number or Paral Route Number. City or Town. State, Zip Code) 19c. Location - City or Town. State, Zip Code) 20b. Mean of Deposition 18brural 2 (Charnation 3) Elemental 10 Date 20b. Location - City or Town. State 20b. Date 20b. Location - City or Town. State 20b. Please of Specially 21. Signature of Funeral Sanco Luffices 22a. Part Coder the disease, or complication that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest. 22a. Part Coder the disease, or complication that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest. 22a. Part Coder the disease, or complication that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest. 22a. Part Coder the disease, or complication that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest. 22b. Due to (or as a consequence of): 22a. Part Coder the disease, or complication that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest. 22b. Due to (or as a consequence of): 22c. Lucy Enter Lunderlying 22 | - inch | E I | | | +) SC | | | E | C PUBLIC | SCHOOL |
| Sequentially list conditions | | | | | | | 1 | | Maiden Sumame) | |
| CLORIA HOWARD/DAUGHTER Comment | F | 0 | | - Drieth | 105 | Mailing Address /Street | | | City or Town Sta | te. Zin Code) |
| Date | 1 | | | | | | | | | |
| 21. Signature of Euroria Service Usersee 22. Name and Address of Facility 23. Part Februshed disease or complications that caused the death. Do not enter the mode of cying, such as cardiac or respiratory arrest, inches and cause (Final Sease or conditions) in death) 23. Part Februshed disease or complications that caused the death. Do not enter the mode of cying, such as cardiac or respiratory arrest, inches and cause (Final Sease or conditions) in death) 24. Part Februshed disease or complications that caused the death. Do not enter the mode of cying, such as cardiac or respiratory arrest, inches and cause (Final Sease or conditions) in death) 25. Sequentially list conditions, if any, leading to immediate cause from the cause of t | | 1 | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F | Removal from State | 20b. Place of cemeter | Disposition (Name of y, crematory or other pla | 2-7- | Date 2 | 20c. Location - City CHELTENHA | y or Town, State AM, MD |
| Sab Part Extent the disease or complicated in the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROSIS CORONARY ARTERY DISEASE | | + | | ee | allow to arrive | 22 Name and Add | | | | |
| Sequentially list conditions | | | shock, or heart failure. List only o Immediate Cause (Final | ications that caused ne cause on each lin | the death. Do r | | | | est, | Interval Between Onset and Death |
| The standing in death) Last | | | resulting in death) | Due to (or as | a consequence | of): | | DIDUIN | | |
| PERIPHERAL ARTERY DISEASE 20YEARS | | miner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as | | | | | | 20YEARS |
| FFEMALE: 23b. Was decedent pregnant in the past 12, months? 1 Live birt 12 Testal death 1 Live birt 13 Live 12 Live 13 Live | 1 | cal Exa | resulting in death) Last | Due to (or as | | | ASE | | | 20YEARS |
| HYPERLIPEMIA 1 Yes 2 No 3 Probably 4 Winknow | | ysician/Medi | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | 1 ☐ Live birth 4 ☐ Pregnant at | 2 Fetal death | | су | | | |
| 25. Was case referred to medical examiner? 1 | | þ | | ntributing to death b | ut not resulting in | the underlying cause (| iven in Part I. | | | |
| 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28b. Describe how injury occurred 28c. Injury at Work? 28b. Location (Street and Number or Rural Route Number. 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how | | ompiete | | | | | | autops | sv pric | or to completion of cause of the |
| 1 1 1 1 1 1 1 1 1 1 | | e . | evaminer? | | | | 0.75 | ath (Check onl on | 10 | |
| 2 Accident 3 Suicide 4 Homicide See. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29m. Certifier (Check only one) 29m. Certifier (Check only one) 29m. Signal are and title of certifier 29m. Signal are and title of certifier 29m. Signal are and address of person who completed cause of death (Item 23a) (Type, Print) 14314 | | | 1 Yes 2□ No | 1 Inpatie | | tpatient 3L DOA | 4 | | | (Specify) |
| 29a. Certifier (Check only one) 29b. Signapere and title of certifier 29b. Signapere and title of certifier 29b. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29a. Certifier (Check only one) 29b. Signapere and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signapere and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) | | ation: | 1 Natural 5 Pending 2 Accident investigation | (Month, Da | | | | | | |
| 29a. Certifier (Check only one) 29b. Signapere and title of certifier 29b. Signapere and title of certifier 29b. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29a. Certifier (Check only one) 29b. Signapere and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signapere and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) | | ertific | determined | 200. Flace of III) | | rm, street, factory, offic | е | 28f. Location (S City or Town | treet and Number n, State) | or Rural Route Number, |
| D0042049 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14314 Mariboro, MD 25772 | | | (Check only 2 Medical Exam | iner: On the basis of | of examination ar | a, death occurred at the | time, date and place opinion, death occu | e, and due to the curred at the time, d | ause(s) and mann date and place, and | er as stated. d due to the cause(s) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14314 Old, Mariboro, MD 25772 | | di | |) | 10 | | | 2 | | |
| | | × | Lob. Olgital To and this or To | | | | | | 00 | |
| | | Me | Men 6. U | leeur | le- | 111111111111111111111111111111111111111 | | construction of | . 60 | 12-2012 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| lark Steven Ho | lter | 1- For State | ate of Maryla | | artment of <i>rtificate of</i> | | d Menta | | 201 | 12 0452 |
|--|----------------------------------|---|--|-------------------|-----------------------------------|--|------------------------|-------------------------------------|------------------------------------|---|
| Physici | | 1. Decedent's Name (First, Midd | le,Last) | | | | | 2. Date of De | Reg. No. ath Day Year | 3. Time of Death |
| Medical Exam | iner | Mark S. Holte 4a. Facility Name (if not institution | n give street and nu | mber) | | b. City, Town, or | Location of I | | 10, 2012 4c. County of De | 0554 hrs |
| | | 314 Carey Avenue Salisbury Wicon | | | | | | | | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. | last birthday) | If Under 1 Year Months Days | $\overline{}$ | 24Hrs. 8. Date of B | irth(MM/DD/YYYY) 9. I | Birthplace (State or eign |
| Director | | 216-96-8396 | 1XM 2 F | 5 | 1 Yrs. | Wortens | nouis | 03/25 | /1960 | Country)Maryland |
| yns | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Locati | on | | | | 10d. Inside City Limits |
| * | 7 | MD Wico | mico | Sa | alisbury | 7 | | | | 1 Yes 2 X No |
| Maryland • 28a-f show | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of What Co | ountry? |
| ith the 23a or notified | g gig = 514 carey rivelide 2:001 | | | | | | | | | |
| eath wi | Funer | 11. Marital Status 1 Never Married 2 M | arried Armed Fo | rces? | | | | uerto Rican, etc.) | White, etc. | erican Indian, Black, |
| after de ni", or | by F. | 3 Widowed 4 Div | 1 Yes vorced If Yes, Give Year or Dates: | 2 X No | 1 | Yes 2 X No | specify: | | Specify: [W] | nite |
| hours natur | | 15. Decedent's Education (Spe | cify only highest grad | | | 's Usual Occupat est of working life. | | | 16b. Kind of Busines | s/Industry |
| 136 hin 72 e. than " | Completed | Elementary/Secondary (0-12) | College (1- | -4 or 5+) | Insul | ation In | nstall | er | Constru | ction |
| 21215-0036 21215-0036 Juld be filed within 7 I Mental Hygiene. marked other than ic event, the Medica | | 17. Father's Name (First, Middle | , Last) | | 1 | | | Name (First, Middle, | | |
| 21215-C ald be filed v Mental Hygi marked oth | o Be | Patrick Holte 19a. Informant's Name/Relations | | | 19h Mailing | Address (Stree | | ret Ann K | een mber, City or Town, Sta | ate Zin Code) |
| nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after of Fleath and Mental Hygiens. If If then 21's marked other than "natural?", other traumatic event, the Medical Examiner | To | Dominick Poll | | other) | , , | ,- | | | k, Michiga | |
| - P = = = | | 20a. Method of Disposition 1 Burial 2 X Cremation | | 20b. | | tion (Name of cer | | Date | 20c. Location - City | |
| Baltimore, permit. Pages I as Department of He Important: If ite | | 4 Donation 5 Other S | | III State | tro Cre | matory. | Inc. 0 | 2/13/2012 | Baltimore | Maryland |
| Baltimo permit. Page. Department o Important: injary or oth | | 21. Signature of Funeral Service | | | 22. N | ame and Address | of Facility | E. F. Las | sahn Funera | al Home, P.A. |
| Physician | | 23a. Part I. Enter the disease, or | complications that ca | used the death | n. Do not enter th | 750 Bela e mode of dying, | air Ro such as card | ad - King diac or respiratory ar | rest, shock, or heart | ryland 21087 Approximate Interval |
| /Medical Examiner | | failure. List only one cause Immediate Cause (Final disease | on each line. | | | | | oxication | | Between Onset and Death |
| Examine | | or condition resulting in death) | Due to (or as a | consequence o | of): | | | | | |
| | Jer. | Sequentially list conditions, if any, leading to immediate | Due to (or as a | consequence o | of): | | | | | 1 |
| 0.4 | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a | consequence o | of): | | | | | |
| cuted cuted transit | | events resulting in deathy Last | d | | | | | | | |
|), be exe sician a | edical | X UNPENDED | AMENDED | 23a,27, | 28a-f,p | er me,g9 | 24 2-2 | 22-12 sm | | |
| 876(tificate ng phy | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | | utcome of preg | | al death 3 | Ectopic pr | regnancy | 23d. Date of deliver Month | ery Day Year |
| Box 68760 te death certificate the attending physical ted for use as the bh | Physician/M | | 4 Pregna | ant at time of de | eath 5 Oth | er (Specify) | | | | |
| P.O. By that the de ned by the detached i | | Part li. Other significant condit | | | esulting in the u | nderlying cause g | iven in Part I | l. 23e. Did t | obacco use contribute | to the cause of death? |
| , P.O. ires that the signed by | d by | | | | | | | 1 Ye | es 2 No 3 P | robably 4 🗹 Unknown |
| ords, w requir | Completed | | | | | | | 24a. Was auto | psy prior to | autopsy findings available o completion of cause of |
| Reco The law cate has | Com | | | | | | | 1 ✓ Yes | ormed? death′ 2 No 1 ✓ | |
| Vital Rec ysician: The his certificate director, page | Be | 25. Was case referred to medica examiner? | Ulara Sala | patient 2 | ER/Outpatient | | | heck only one) | Residence 6 🗸 Ott | nor: Soono |
| 1 of VI Jing Physic After this funeral dir | To | 1 Yes 2 No 27. Manner of Death | 28a. Date o | | 28b. Time of In | | y at Work? | | how injury occurred | ior. occina |
| ion tendin eath. tor: A | atior | 1 Natural 5 Pend 2 Accident Inve | | 10-12 | fd 055 | 4 hars ¹□ Y | es 2 🗶 N | unknow | n | |
| Division of Vital Records, tal or Attending Physician: The law requint at a fair death. In Director: After this certificate has been sided in by the funeral director, page 2 should be | Certification: | 3 Suicide 6 Cou | d not be 28e. Place | | | t, factory, office b | uilding, etc. | or Town. | State) 314 Care | Rural Route Number, City |
| Divineral of the filled | | 29a. Certifier | (0,000)) | | idence | ed at the time da | te and place | | ury, MD. se(s) and manner as st | ated |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 thoust after death. To the Functal Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b | Medical | (Uneck only | | f examination a | | | | | and place, and due to | |
| E \$ E 8 | Me | 29b. Signature and title of certific | | , (| 1 | 29c. License | | | 29d. Date signed (M | |
| | | Ch UL | 111 | $\Delta \Delta$ | | 0.0. | /I. ∟. | | February 11, 20 | J12 |
| | | 30. Name and address of person Zabiullah Ali, M.D. | who completed cause Assistant Medica | | | altimore Stree | et, Baltim | ore, MD 21223 | | |
| | tate | 31. Date filed (Month, Day, Year) | | gistrar's Signat | | | | | | |
| Regis | trar | FFR 1 6 2012 | Margaret | A. 100 | The | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:00 P M 2012 Donald Byron Joy January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel 1400 Congress Court 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 1 🛣 M 2 □ F Director 005-44-1318 66 8/23/1945 Maine 28a-f shov ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Marvland Annne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 USA 1400 Congress Court ral", or items? within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify "natural", Specify. White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Manager years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H is marked o ည Byron Walter Joy Geraldine Mitchell Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 1400 Congress Court, Annapolis, MD 21409 Pilar T. Joy/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛣 Other (Specify) Entombment 2/3/12 Lakemont Cemetery Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
18 months Immediate Cause (Final disease or condition Physician Adenocarcinoma of unknown primary Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed and-tra Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending death. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of c 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2003 Medical Pkwy., Barry Meisenberg, M.D. Annapolis, MD 21401 31. Date filed (Month, Day, Year) 1 2012

DHMH 17 Rev 06-2011

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

| | | _ AMEND#12 | | Type or Pri State of M | | | | | | | - | | _ | ible. | | |
|---|---------------------|--|--|---|--------------------|--------------------------------------|--------------------------------------|-------------------------|-------------------|-----------------|---|---------------|----------------|-----------------------|--|------------|
| | | State 2/2/2 Registrar | 012 AACO 1 | State of M HEALTH DEPT. | CMH | | rtificat | | | | | Reg. No | -2.0 | 12 | 045 | 29 |
| Physicia | | Decedent's Name (Fin James | | elly | | | | | | | 2. Date of Dead Month | Da | b 2 | Year | 3. Time of De | |
| Medic Examine | | 4a. Facility Name (If not Assisted L | | | ssion | nate Care | | | Location o | | San day | 4c | County | of Death | | |
| Funeral Director | | 5. Social Security Numb 129-24-866 Usual Residence of De | 65 1 2 | | e (In yrs. I 79 | ast birthday) Yrs. | If Unde Months | n 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bird (Month, Da June 05 | y, Year) | 32 | Cou | nplace (State or F ntry) York | oreign |
| aryland a-f show fied at | ector | 10a. State 10k | b. County Anne Aru | ındel | | y, Town or Lo Sever n | | :k | | | | | | | 10d. Inside City I | |
| vith the M. 23a or 28 | Funeral Director | 10e. Street and Number 389 Stonehouse Drive | | | | 10f. Zip | Code 21146 | | | | - | tizen of V | Vhat Cou | intry? | | |
| ter o | ρ | 11. Marital Status 1 Never Married 3 Widowed 4 | 2 🗶 Married | 12. Was Decedent B Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates. 1 | No 19 | 55 | Was Deced If Yes, special | | | | ecify Yes or No- Rican, etc.) | | | k, White | ican Indian, , etc. White | |
| iin 72 houn ie. han "natui e Medical | Completed | | 5. Decedent's Edi only highest grad | ucation de completed) College (1-4 or 5 | | 16a. Dece (Give life. D | kind of wo | rk done a e retired) | luring mos | t of work | ing | | (ind of Bu | | | |
| e filed with ntal Hygier ed other t event, the | To Be C | 17. Father's Name (First, Michael K | . , | 5+ | | Pro | ject | Mana | 18. Moth | | e (First, Middle, et Guinr | Maiden | Surname | | tes Navy | Y |
| 2 should b th and Me 27 is mark traumatio | | 19a. Informant's Name/ | Relationship (Typ | | | | _ | | and Numbe | er or Rura | al Route Numbe | r, City or | Town, S | | | |
| Page 1 and lent of Heal nt: If item ry or other | | 20a. Method of Disposit | tion Cremation 3 🗆 I | Removal from State | 0 | Place of Disponentery, cree Veter | osition (Nar matory or o | ne of other plac | e) | Janua | Date ary 27, | 20c. Lo | ocation - | City or T | Town, State | |
| permit. F Departm Importa any inju | | 21. Signature of Funeral | | | | | | | | | | | | | neral Ho D 21146 | ome |
| Physician/ | | Immediate Cause (Final disease or condition | ilure. List only on | e cause on each line |) . | | er the mod | | _ | | | | | | Approximate Interval Betwe Onset and Dea | en |
| Medical Examiner | Į. | resulting in death) Sequentially list condition | ions, | Due to (or as a | <u>'</u> | , | | | | | <u>-</u> | | | | | |
| executed an and rial-transit | Examiner | Sequentially list conditi- if any, leading to immed cause. Enter Underlying Cause (Disease or injur- that initiated events resulting in death) Last | ry (| Due to (or as and compared to the compared to | | | | | - | | | | | | | |
| . ⊒. a e | _ | | | d | | | | | | | | | | | | |
| law requires that the death certificate be as been signed by the attending physici e 2 should be detached for use as the br | by Physician/Medica | IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | ths? | 23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown | 2 Feta | aldeath 3 | ☐ Ectopic ☐ Other (s _f | | у | | | | 23d. Dat Mo | | very Day Yea | ar |
| uires that the signed by all the deta | ed by Pi | Part II. Other significan | | _ | ut not res | sulting in the u | underlying | cause giv | en in Part | l. | | | | | the cause of deat | |
| he law req ite has bee oage 2 sho | Completed | | | | | _ | | | | | 24a. Was autor perfo 1 \subseteq Yes | osy ormed? | ķ | orior to co death? | opsy findings ava ompletion of caus | |
| sician: The la certificate ha lirector, page 2 | Be | 25. Was case referred to examiner? | - | Jospital: | | | | | ace of Dea | th_(Chec | k only one). | | ع ل | | | |
| Physic this c | 유 | 1 Yes 2 No | 0 | lospital: 1 Inpati | - | ER/Outpatie | | Othe | 4 ∐ Nı | | ome 5 Resid | dence 6 | Othe | er (Specif | 9 | |
| ttending death. :tor: After / the fune | Certificate: | 1 Natural 5 | ☐ Pending Investigation ☐ Could not be | (Month, Day | , Year) | injury | М | work | | | 28d. Describe h | | | | I Davida Alimahan | |
| | | 4 ☐ Homicide | determined | building, etc | . (Specify | /) | | | | | City or Tow | n, State, |) | | al Route Number, | |
| ne Hos in 24 ho ne Fune pletely | Medical | (Check 2 🗌 I | Medical Examin | ner: On the basis of e Practitioner: To the | xaminatio | n and/or inves | tigation, in | my opinio | n, death o | curred at | t the time, date a | nd place | e, and due | to the ca | ause(s) and manne | er stated. |
| vithi To th | _ | 29b. Signature and title | | 0. 1 | , | | | . License | | > 1 | | | | | Day, Year) | |
| | | 30 Name and address of | of Arson who co | m, D. | eath (Item | n 23a) (Type, F | Print) | | 75. | | | | | | 20,20 | -1 4- |
| 4104 | | Mohit A | Jegi 86 | sol Veter | 975 | Muy | Such | 200 | 4 M | ille | sville | , m | D: | 2110 | 8 | |
| State Registra | e r | 31. Date filed (Month, Da | AN 25 20 | 012 32. Registra | ir's Signa | ture . | park | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30, 2012 January 6:14 p Thomas Walter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 130 College View Blvd. Westminster If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Min. (Month, Day, Year) une 1. 1915 Months Days Hours Country) 96 218-10-7238 Director June MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? Funeral 21158 130 College View Blvd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes No Black White etc. 1 Never Married 2 Married <u>გ</u> Maryland 21215-0036 1 Yes XX No Specify: Yes, Give 3 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Lee's Motel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental h Important: If item 27 is marked any Injury or att ည Hattie Carr Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD 130 College View Blvd. Nadine Lee/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 2/4/2012 Pleasant Valley, MD Pleasant Valley Cem. 21. Signature of Funeral Service License 22. Name and Address of Facilitritts Funeral Home & Chapel, PA 412 Washington Rd. 21157 Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysiciani Arteriosclerotic cardiovascular disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consumence of If any leading to immediate cause. Enter Underlying Exami use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year 2 No 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Division of Vital Records, 2X No 3 ☐ Probably 4 ☐ Unknown Diabetes mellitus 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate b Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral dil 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 K Natural 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29a. Certifier (Check

only one)

and title of certifie

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 1 2012 incur.

Westminster, MD 21157 Parker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Howard G. Lanham, M.D. 215 Washington Heights Medical Center

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D17040

29d. Date signed (Month, Day, Year)

February 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ LINTHICUM LARA LOUISE 08:50 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Howard Columbia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 216-03-7897 Director 1 🗆 M 2 🗶 F 94 02/10/1917 MD or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State be notified at Director Baltimore Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 27 is marked other than "natural", or items 23 traumatic event, the Medical Examiner must United States 1227 Stamford Road 21207 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 2 **X**No 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bakery Manager Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lottie Hannah King Richard Lowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or any injur 9531 Valley Mede Court Ellicott City, MD 21042 Bruce Ash - Nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 02/04/2012 Elkridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses uanita 4112 Old Columbia Pike Ellicott City, MD 21043 thomas 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOGENIC SHOCK Physician/ disease or condition Medical resulting in death) **Examiner** DISEASE ARTERY COROMARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events AORTIC sician and burial-transit EVERE or Attending Physician: The law requires that the death certificate be executed ũ resulting in death) Last aftending physician Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FFMALE nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mont 1 Yes 2 No ó Month Day Year signed by the a 1 Yes 2 D 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð BACTEREMIA 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 2 100 1 Yes ည Numpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) After this completely filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 24 hours after death Funeral Director: A Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title of certifie

Registrar

State

31. Date filed (Month

arke

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PHYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAN TIII JEAN MD 3230 N. 12,33e 123

32. Registrar's Signature

Brekens

29d. Date signed (Month, Day, Year

JAN

Swite

31

2012

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| | | State of Maryland | | artment of I <i>tificate of I</i> | | and IV | , , | _ | 0.10 | 01 522 | | |
| iar | , | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Deatl | | · U - 1 · 6. | 3. Time of Death | | |
| dica | al | Shirlene Mitchell | | | | | January | | 2012 | 11:46Рм | | |
| ine | er | 4a. Facility Name (if not institution, give street and number) 344 Highland Dr. Apt 103 | | 4b. City, Town, o | | | | _ | unty of Deatl | rundel | | |
| al | Ť | 5. Social Security Number 6. Sex 7. Age (In yrs. last to | birthday) | If Under 1 Year Months Days | | | 8. Date of Birth (Month, Day, | | 9. Birt | hplace (State or Foreign | | |
| or | | 247-84-2782 | Yrs. | IVIOITII S Days | Hours | IVIIII. | Jan 28 | 194 | | . C . | | |
| | tor | 10a. State 10b. County 10c. City, To | own or Loc | cation | | | | | | 10d. Inside City Limits | | |
| | Director | | en B | urnie | | | | | 7 | 1 ☐ Yes 2 X No | | |
| | | 10e. Street and Number | | 10f. Zip Code | \ C 1 | | 1 | | of What Co | untry? | | |
| | Funeral | 344 Highland Dr. Apt 103 11. Marital Status 12. Was Decedent Ever in U.S. | 13. V | 210 Vas Decedent of H | ispanic Ori | igin? (Spec | cify Yes or No- | | ISA Race - Amer | ican Indian | | |
| | | 1 ☐ Never Married 2 ☐ Married ☐ Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give | | f Yes, specify Cuba | | | Rican, etc.) | | Black, White | , etc. | | |
| | Completed by | 3 Wildowed 41 Divorced Year or Dates. | | | | | | | ecify: Bla | | | |
| | mp | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | (Give k | lent's Usual Occup kind of work done (D NOT use retired) | during mos | t of workir | 19 | | of Business/I | ndustry Washingtor | | |
| | Be Co | 12th 0 | Tele | phone C | pera | tor | | | al Ce | | | |
| | To B | 17. Father's Name (First, Middle, Last) Unobtainable | | | | | (First, Middle, M | | name) | | | |
| | | | 9b. Mailin | a Address (Street | | | Route Number | | ın State Zin | Code) 21061 | | |
| | | Tyrone R. Mitchell(Son) | 44 H | ighland | Dr. | Apt | : 103 G | 1en | Burni | le, Md. | | |
| | | 1 Burial 2 X Cremation 3 Removal from State ceme | etery, crem | sition (Name of natory or other plac | | | | 0c. Locati | ion - City or | Town, State | | |
| | | 4 Donation 5 Other (Specify) Met | | remator | - : | 2-10 | | | | e, Md. | | |
| 5 | 21. Signature of Funeral Service Licensee Winame Research ScilitSons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 | | | | | | | | | | | |
| | | 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate | | |
| / | | 1 1 | nce | phaloga | thus | | | | | Interval Between Onset and Death | | |
| al er | | resulting in death) Due to (or as a consequence) | e of): | 1300 | 46 | | | | | | | |
| | ner | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence) | e of): | <i>mse</i> | Nac | | | | | | | |
| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events c | | | | | | | | | | |
| - 1 | _ | resulting in death) Last Due to (or as a consequence | e of): | | | | | | | | | |
| | Completed by Physician/Medical | d | | | | | | | | | | |
| | an/r | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal de. | ath 3 □ | Ectopic pregnanc | :v | | | 23d. | . Date of deli | very | | |
| | ysici | in the past 12 months? 1 Yes X No 4 Pregnant at time of death 9 Unknown 9 Unknown | 1 5 🗆 | Other (specify) | , | | | | Month | Day Year | | |
| ē | y Ph | Part II. Other significant conditions contributing to death but not resultin | g in the ur | nderlying cause giv | en in Part | l. | 23e. Did toba | cco use c | ontribute to | the cause of death? | | |
| | ed D | | | | _ | | 1 🗆 Yes | 2 🗆 N | lo 3 🗆 Pro | obably 4 Unknown | | |
| | plet | | | | | | 24a. Was an autopsy | | 4b. Were auto | opsy findings available ompletion of cause of | | |
| | 5 | | | | | | perform | ed? No | death? | 2XNo | | |
| Ġ | ge | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Input of the property of t | | TOthe | ace of Deater: | | | | | | | |
| | e: 0 | 27. Manner of Death 28a. Date of injury 28b | . Time of | 28c. Injun | 4 ∟ Nu ⁄at | | ne 5 KResider 8d. Describe hov | | | (y) | | |
| | IIca | 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be | injury | M 1 🗆 | ? Yes 2 🗌 | No | | | | | | |
| | Certificate: | 4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify) | farm, stree | et, factory, office | | 2 | 8f. Location (Stree City or Town, | | mber or Rura | al Route Number, | | |
| 3 | Medical | 29a. Certifier 1 Certifying Physician: To the best of my knowledge | e, death o | ccurred at the time | , date and | place, and | d due to the caus | e(s) and m | nanner as sta | ted. | | |
| | Mec | (Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practitioner: To the best of my kn | d/or investi nowledge, o | death occurred at t | he time, dat | curred at t te and plac | e, and due to the | cause(s) ar | nd manner as | stated. | | |
| | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tanvary 31, 2012 | | | | | | | | | | | |
| | | 30. Name and address of person who completed cause of death (Item 23a |) (E D | -1-1) | | | | ANO | ving 3 | 1,2012 | | |
| | | Maemeka Agajeln 1411 Madis | ion f | ank Drive | - Svi | te 41 | , Glen | Bur | nie V | ND 51061 | | |
| ate :rar | | 31. Date filed (Month, Day, Year) FEB 01 2012 | 1. 1 | ak | | | | | | | | |
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Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 4;13 /10 4a. Facility Name (if not institution, give street and number) Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Dove House botal Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) 1 □ M 2 □**x Director** Usual Residence of Decede 83 3/24/1928 Hanover PA 28a-f shov 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 Xo Westminster MD Carroll 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funera 21158 3815 Backwoods Rd within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Yes 2 **X**No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Margaret S. H. Boyer Harry Shue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3894 Swamp Rd Felton Pa 17372 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important; If item 27 is any injury or other Wanda J. SellDaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bixlers Church Cemetery 2/14/12 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Westminster, MD 4 Donation 5 Other (Specify) 17340 Signature of Funeral Service Licenses 22. Name and Address of Facility Littles FH 34 Maple Ave. Littlestown PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NB0 disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of and I-transit Exami the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 1 Yes 2 9 Unknown 2 No been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate has Yes 1 L Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other 2 X No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Lammi 00051705

Jun45

Registrar

DHMH 17 Rev 06-2011

MD.

349 Malcoim Dr. Westminster, MD 2157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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egistrar's Sgnature

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FEB 10

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:13 MILLER PEBRUARY 2012 HILDA MAE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JESTMINSTER CARROLL HOSPITAL CENTER ARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number MD Country) **Funeral** 1 🗆 M 2 🔀 F Min. 6-14-1926 Months Days Hours 219-20-0737 85 **Director** Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Carroll Finksburg 1 Yes 2 X No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21048 Funeral 1935 Deer Park Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha Office Secretary 12 injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Hughes Elvie Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)Husband 1935 Deer Park Rd., Finksburg, MD 21048 Russell B. Miller Jr. permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Evergreen Memorial 2-8-12 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Lineral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home homes 21157 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART Ptyrician/ FAILURE disease or condition resulting in death) Medical Examiner ことにとららえ ORONALY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury s been signed by the attending physician and should be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month in the past 12 months?
1 ☐ Yes 2 ☑ No Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Yunknown PULMONARY EDEMA Completed 24b. Were autopsy findings available prior to completion of cause of death? PNEUMONIA 24a. Was an After this certificate has PERIPHERAL VASILLAR DISEASE performed? Yes 2 No 1 🗆 Yes 2 🖪 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral I Medical b the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examine Certifying/Nurs ioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signa D0060293

State Registrar 30. Name and address o

MURTUZA

MEMORIAL AVE. WESTMINSTER MD 21157

n who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Mehaffie, Anthony PSR. Ozlowin 12:09

| | | | Please 1 | ype or Prin | | | | | | | | _ | e. | |
|--------------------------------|--|------------------|--|--|-----------------------------------|----------------------------------|--|------------------------------|------------------------|---------------------------------|-----------|----------------------------|---------------|--|
| | | - | For State Registrar | State of Mar | ryland / | | artment of f tificate of l | | and iv | | Reg. No | ~ ~ 1 | 2 | 04535 |
| | Division | | Decedent's Name (First, Middle, Last) | | | | | | | 2. Date of Dea | ath | | | 3. Time of Death |
| | Physicia Medic | al | Anthony P. 4a. Facility Name (if not institution, give st | r Location o | | Feb. 2 | | 2012 Yea | | 12:09 p ^M | | | | |
| | Examin | er | | | | | | | | | | | | -y |
| | Funeral Director | | 5. Social Security Number 6. Sex 213–44–7595 | | Birthpla Do <i>untr</i> | ace (State or Foreign | | | | | | | | |
| | 3 | ń. | Usual Residence of Decedent | 8/17/1 | 946 | | T., | MD | | | | | | |
| | arylanc a-f sho fied at | Director | 10a. State 10b. County MD Carrol | | 10c. City, To | | npstead | | | | | | 10 | d. Inside City Limits 1 Yes 2 No |
| | ye 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. It of Health and Mental Hygiene. If it item 27 is marked other than "natural", or items 23a or 28a-f show If item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | Funeral Dir | 10e. Street and Number 2439 Fairmount Rd. | , #35 | | | 10f. Zip Code 21 0 | 74 | | | 10g. C | itizen of What | Countr | y? |
| | death items ner mu | | Transaction Grands | 2. Was Decedent Eve Armed Forces? | | 13. V | Vas Decedent of H f Yes, specify Cuba | lispanic Orig an, Mexican | gin? (Spe n, Puerto | cify Yes or No- Rican, etc.) | | 14. Race - Ar Black, WI | | |
| 036 | s after ral", or Exami | ed by | 1 Never Married 2 Married 3 XWidowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates. | 0 | 1 | ☐ Yes 2 X No | Specify: | | | | Specify: V | vhit | te |
| 15-0 | 72 hour "natu edical | Completed | 15. Decedent's Edu (Specify only highest grad | | 16 | (Give h | lent's Usual Occup | during most | t of worki | ng | 16b. l | Kind of Busines | ss/Indu | ıstry |
| 212 | within giene. | | Elementary/Secondary (0-12) | College (1-4 or 5+) | t | | NOT use retired) driver | | | | СЈ | Miller | T1 | rucking |
| pu | e filed vatal Hyged of the event, | To Be | 17. Father's Name (First, Middle, Last) | 551 | | | | | | e (First, Middle, | Maiden | Surname) | | |
| ııyı | ould be od Men marke matic | | William Merle Meha 19a. Informant's Name/Relationship (Typ) | | 10 | 9h Mailin | ng Address (Street | Laur | | | r. Citv o | r Town, State. | Zip Co | ede) |
| , Ma | nd 2 sh salth ar n 27 is ier trau | | Gloria Mehaffie, d | | 2 | 2439 | Fairmour | ıt Rd | #35 , | Hampst | | | | |
| Baltimore, Maryland 21215-0036 | Page 1 ал ment of H. ant: If iter ury or oth | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) | lemoval from State | 20b. Place ceme Ever | of Dispos tery, crem green | sition (Name of natory or other place natory or other place natory). Name and Addre | il Gar | 2/7/ d. | 2012 | | ocation - City | | |
| Balt | permit. Page Department (Important: If any injury or once, | j | 21. Signature of Funeral Service Licensed | M00741 |) | - 4 | Name and Address Nai | | . 1711 | ne rune | | | 107/ | 1 |
| г | | | 23a. Part 1. Enter the disease, or complishock, or heart failure. List only one | cations that caused to | he death. Do | | | | | | | 1102 | | Approximate Interval Between |
| | h, i i n/ Medical | 0 1 | Immediate Cause (Final disease or condition resulting in death) | arten | 0201 | ero. | he ca | 5 dio | Uas | allas | d | 15892 | | Onset and Death |
| | Examiner | | | Due to (or as a | consequence | e of): | | | | | | | | |
| h | sit d | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a c | consequenc | o U(;: | | | | | | | | |
| | executed an and irial-transit | Exar | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a | consequence | e of): | | · · · · | | | | | + | |
| 09 | | dical | | | | | | | | | | | + | |
| Box 68760 | certifica nding p use as | n/Me | ZSD. Was decedent pregnant | 3c. If yes, outcome of 1 ☐ Live Birth 2 | | ath o | Tetorio receno | 014 | | | | 23d. Date of | deliver | у |
| Box | the atte | Physician/Medica | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 Pregnant at t | | | Other (specify) | | | | | Month | [| Day Year |
| s, P.O. | requires that the death been signed by the atte should be detached for | by | Part II. Other significant conditions con | tributing to death but | not resulting | g in the u | inderlying cause gi | ven in Part | I. | | | | | cause of death? |
| Records, | w requir | Completed | | | | | | | | 24a. Was | | 24b. Were | autops | sy findings available upletion of cause of |
| Rec | sician: The law a certificate has b lirector, page 2 s | Com | | | | | | | | autor perfo | rmed? | death | 1? | No No |
| Vita | sician: certific lirector, | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | ospital: | | Outpation | Oth | lace of Dea | | me 5 Resid | danca | 6 C Other /Sr | noif il | |
| of | ding Physician: h. After this certific funeral director, | ate: To | 27. Manner of Death 1 ✓ Natural 5 ☐ Pending | 28a. Date of injury (Month, Day, | 28b | o. Time of injury | 28c. Inju | ry at k? | | 28d. Describe h | | | <i>веспу)</i> | |
| Division of | pital or Attend burs after death eral Director: / filled in by the | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury building, etc. | | farm, stre | | Yes 2 | | 28f. Location (5 City or Tow | | | Rural F | Route Number, |
| Ω | To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but | Medical | 29a. Certifier 1 Certifying Physic (Check 2 Medical Examinonly one) 3 Certifying Nurse | er: On the basis of exa | amination and | d/or invest | tigation, in my opini | ion, death or | ccurred at | the time, date a | and plac | e, and due to the | ne caus | se(s) and manner stated. |
| | To the Hosp within 24 ho To the Fune completely f | Σ | only one) 3 L Certifying Nurse 29b. Signature and title of certifier | , activities, to tile | Social Hy Ki | ouge, | 29c. Licens | | and pic | | | ate signed (Mo | | |
| | J _h | | 100 | | Cul | | 5 | 541 | 10 | C i | 00 | 102 | 12 | 012 |
| Ū | SAS | | 30. Name and address of person who co | impleted cause of dea | atri (item 23a | PGC | ye og | jeu | 17 | OING | -lu | und | 7 | |
| | Sta Registr | | 31 Date filed (Month Day Year) | 32. Registrar | 's Signature | 4. A | back | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 8:15 P Samuel Matz January 20, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Carroll County **Examiner** Hampstead 4180 Double Tree Lane If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 84 Director 214-22-4236 1 **X** M 2 □ F Maryland May 8, 1927 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Oc. City, Town or Location 10b. County Director Hampstead Carroll County Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4180 Double Tree Lane 21074 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 X Yes 2 □ N Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes Give 1945white 3 X Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) furniture sales salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yetta Black pe Harry Matz ige 1 and 2 should be nt of Health and Men E. If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Allan E. Hemdler / nephew 4180 Double Tree Lane Hampstead, Maryland 21074 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. Date 26, Page 1 Garrison Forest Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State injury or Owings Mills, Maryland Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licente 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074 M01072 urvis 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicial precedur. P.O. Box 68760 the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death signed by the at Id be detached for 2 No Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 Tyes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes Yes director, 25. Was case referred to medical examiner?
1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No injury 5 Pending Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical C if ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie M. dical Examiner: On the big is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Carphying Nurse Fractitional Taylors best of my knowledge, death or manded at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of

31. Date filed (Month, Day, Year)

JAN25

30. Name and address of person who completed couse of death (Item 23a) (Type, Print)

32

Registrar's Signature

29d. Date signer (Month, Day, Year)

| -00552 | | Please Typ | oe or Print in | Black In | delible In | k. Ensi | ure | All Copi | es Are L | .egibl | e. | | |
|---|-----------------|---|--|---------------------------|---|--------------------------|---------|------------------------------------|---------------------------------------|-----------------------|-------------------------|-------------------|--|
| ward Clinton I | • | rs St 1- For State | ate of Maryla | | | | and | Mental H | lygiene | | 20 | 12 | 0453 |
| | | Registrar 1. Decedent's Name (First, Midd | In Loot) | Cer | tificate of | Dealn | - | | 2. Date of D | Reg. No | | | Time of Death |
| Physicia edical Exami | | | C. Myers, | Jr. | | | | | Month January | Day | Year 012 | 3. | 0037 hrs |
| | | 4a. Facility Name (if not institution 140 College View Bou | n, give street and nur | mber) | 4 | o. City, Town Westmin | | ocation of Deat | h | | c. County of Carroll | Death | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. la | ast birthday) | If Under 1 | rear | If Under 24Hr | s. 8. Date of | Birth(MM | | | lace (State or |
| Director | | 219-74-5342 | 1⊠M 2□F | 53 | Yrs. | Months E | Days | Hours Mi | n. Mar | ch 1 | 0, 19 | Foreign 8Count | ry) MD |
| any | } | Usual Residence of Decedent 10a. State 10b. County | | 10c. City. | Town or Location | n . | | | | - | | 110 | Od. Inside City Limi |
| and show a | 5 | FL Le | е | | . Myers | | L | | | | | | Yes 2 N |
| Maryl 28a-f | Director | 10e. Street and Number | | • | | 10f. Zip Cod | е | | | 10g. Cit | tizen of Wha | t Country | n |
| h the 3a or | | 17670 Broad | way St. | | | 339 | 31 | | | | USA | | |
| ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 17 is marked other than "natural", or items 23a or 28a-f show matte event, the Medical Examiner must be notified at once. | Funeral | 11. Marital Status 1 Never Married 2 M | arried Armed Fo | | If Ye | | | anic Origin? (S Mexican, Puert | | No- | 14. Race - White, | | n Indian, Black, |
| after d | by F. | | orced If Yes, Give Yeer or Dates: | 1978–19 | 82 1 | Yes 2 🔀 | No . | specify: | | | Specify: | Whi | |
| hours natur Exam | Pe | 15. Decedent's Education (Spe | | | 16a. Decedent during mo | | | n (Give kind of O NOT use re | | | Kind of Busi | | • |
| 36 in 72 than | Completed | Elementary/Secondary (0-12) | College (1- | -4 or 5+) | Owner | Mizore | ш | VAC, In | C | | Heatir C∞l | - | ia |
| d with | ĕ | 17. Father's Name (First, Middle, | Last) | | OWITCE | riyers | | .Mother's Nam | | e, Maider | | .1119 | |
| 21215-0036 and be filed within 7 Mental Hygiene. marked other than it event, the Medica | Be (| Edward C. Mye | ers, Sr. | | | | | Alber | ta S. | Mull1 | hauser | 1 | |
| hould Me Mis man | 2 | | | | | | | and Number or | Rural Route I | Number, C | City or Town, | State, Zi | |
| and 2 shou fealth and Nitem 27 is n | | Dimitri Harbar 20a. Method of Disposition | ugh/Daught | | | | | St. Un | ion Br | | , MD Location - 0 | 2179 | |
| ore, es la a of He If ite | H | 1 Burial 2 Cremation | 3 Removal fro | m State | Place of Disposit crematory or other | er place) | | | | | | • | |
| Baltimore, permit. Pages 1 ar Department of He Important: If ite injury or other tr | | 4 Donation 5 Other S | | Ca | rroll C | | | | | | | | Marylan |
| Baltimore, MD permit. Pages 1 and 2 sh Department of Health and Important: If item 27 in injury or other traumat | | 21. Signature of Funeral Service | Vicensee | | | | | rton Rd | | | | | apel, PA 21157 |
| Physician | \dashv | 23a. Part I. Enter the disease, or | | used the death. | | | | | | | | t / | Approximate Interv |
| /Medical Examiner | | failure. List only one cause Immediate Cause (Final disease | Description of the Contract of | es | | | | | | | | | Between Onset an Death |
| _Admine: | | or condition resulting in death) | Due to (or as a | consequence of | ·): | | | | | | | | |
| | <u>-</u> | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a | consequence of | 7): | | | | | | | \dashv | |
| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated | с | | | | | | | | | | |
| ecuted and - transit | | events resulting in death) Last | Due to (or as a d. | consequence of | ·): | | | | | | | | |
| | Ea | UNPENDED | AMENDED | | | | | | | | | | |
| 760, cate be physic he bur | Me | IF FEMALE: | | utcome of pregr | nancy | | | | - | 23 | Bd. Date of d | elivery | |
| 30x 68760, death certificate be attending physicil for use as the buri | ian | 23b. Was decedent pregnant in the past 12 months? | I I LIVE DI | rth ant at time of dea | oth - | al death | 3 | Ectopic pregn | ancy | | Month | Day | Year |
| Box 68760, e death certificate be ex the attending physician ed for use as the burial. | Physician/Medic | 1 Yes 2 No 9 Uni | known 9 Unknow | | ⊃ Uth | er (Specify) | | | · · · · · · · · · · · · · · · · · · · | | | | |
| P.O. | | Part II. Other significant condit | ions contributing to | death but not re | esulting in the un | derlying caus | se give | en in Part I. | | _ | | _ | cause of death? |
| | od be | | | | | | | | | | ✓ No 3 | | |
| ord: w requas been | Completed | | | | | | | | | topsy | pri | or to com | sy findings availab pletion of cause of |
| Rec The la | É | | | | | | | | 1 ✓ Ye | erformed? | | ath? ✔ Yes | 2 No |
| Vital Pysician: his certifications, | Be | 25. Was case referred to medica examiner? | Hospital: | | | | | Death (Check | | | | | |
| Of VI ing Physic After this uneral dir | 유 | 1 ✓ Yes 2 No 27. Manner of Death | - ' ' ' | | ER/Outpatient | | | ther4 Nursi | ng Home 5 | | ence 6 🗹 | | cene |
| Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director. | Certification: | 1 Natural 5 Pend | 28a. Date of Month Jan 20, 2 | Day Year) 2012 | 28b. Time of Inj 0025 hrs | ury 200, 1 | _ | at vvork? s 2 ✓ No | Driver au | | | | |
| rision Attender dear dear rector | licat | 2 🗹 Accident Inves | stigation 28e Place | of Injury - At ho | ome, farm, street | , factory, offic | _ | | 28f. Locatio | n (Street | and Number | or Rural | Route Number, Cit |
| Div | er. | Cuicide | d not be (Specify) | Major Road | d / Highway | | | | or Town 140 Colleg | n, State) e View E | Blvd., West | minster, | MD |
| Division To the Rospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu | | 29a. Certifier (Check only 1 Certifying Pl | hysician: To the best | | | | | | | | | | au vao (a) |
| To th within To th compl | Medical | one) 2 Medical Exa 29b. Signature and title of certifie | miner: On the basis o and manner st | | iwoi investigatio | on, in my opin | | | acuse time, da | | Date signed | | |
| | | 29b. Signature and title of certifie | | | | | C.M. | | | | nuary 20, | | ⊅ay, ≀€arj |
| 1843 | | 30. Name and address of person | | e of death /Itam | 23a) | | - 1181 | | | | , 20, | | |
| MINK | | Ing Li MD Assista | | | - | Street. B | altin | nore MD 2 | 1223 | | | | |

DHMH 17 Rev 1/2001 OCMF 2006

State 31. Date filed (Month, Day, Year)
Registrar JAN 2 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MORRIS Month Physician/ ARBARA 0330 M 20/2 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Min Hours 74 578-54-1744 Director 1 M 2 F 12/17/1937 Washington D. C. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1

Yes 2 □ No Maryland Prince George's Bowie 10e Street and Numbe o 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 12319 Stonehaven Lane 20715 S. A. S - 12items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian ral", or iten Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 X Never Married 2 Married 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Black. 1 ☐ Yes 2 X No Specify. Specify "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 2 Administrative Assistant Howard University event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မ Stanfield Marazon Howard W. Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 Si an unent of Health an uportant; If item 27 is n vinjury or other Janina Morris/Daughter 3426 Ephron Circle, Bowie, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department of Important; If any injury or 1/24/2012 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home, . Signature of Funeral Service Livensee The 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ 21 disease or condition Medical resulting in death) consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month 5 Other (specify) Day Year Pregnant at time of death ed by the a s been signed by t should be detact to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Other: ٥ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 2143 2012

State Registrar 31. Date filed (Month.

DHMH 17 Rev 06-2011

ANNAPU

Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 2 5 2012

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

per FH State of Maryland / Department of Health and Mental Hygiene

| | | - | FoAMEND#18 per FH State state 1/25/2012 AACO HEALIH I Registrar | of Maryland EPT. CMH | | artment of H tificate of D | | | Reg. No. 2 | 012 | 04539 |
|--------------------------------|---|------------------|---|--|---|---|-----------------------------|---------------------------------|----------------|---|---|
| | Physicia | | Decedent's Name (First, Middle, Last) Giuseppe Mazzeo | | | | | 2. Date of Dea | | 201 ^Y 2 ^{ar} | 3. Time of Death 6:37 P M |
| | Medic Examin | | 4a. Facility Name (if not institution, give street and n | umber) | | 4b. City, Town, or I | ocation of Death | | | unty of Death | |
| | | | 1656 Elkwood Court | 7 / 4 / 4 / 4 | - A 15 1 A 15 15 15 15 15 15 15 15 15 15 15 15 15 | Ans | napolis If Under 24 Hrs. | Lo But of Bit | | ne Arui | |
| | Funeral Director | | 5. Social Security Number 131-40-1111 Usual Residence of Decedent | 7. Age (In yrs. las | Yrs. | Months Days | Hours Min. | 8. Date of Birt 1/13/ | | Ita. | place (State or Foreign |
| | and show 1 at | o | 10a. State 10b. County | 10c. City | , Town or Loc | | | | | 1 | 0d. Inside City Limits |
| | Maryl 28a-f otifiec | irect | Maryland Anne Arundel | | | | nnapolis ———— | | | | 1 🗆 Yes 2 🙀 No |
| | rith the 23a or st be r | Funeral Director | 10e. Street and Number | | | 10f. Zip Code | 21409 | | | n of What Cour SA | ntry? |
| | tems terms | Fune | Armod | ecedent Ever in U.S. Forces? | . 13. V | Vas Decedent of His f Yes, specify Cubar | | pecify Yes or No- | | Race - Americ | |
| 920 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | þ | | es 2 🙀 No Give | | Yes 2 X No | | Triodit, cto.y | Spe | Black, White, ecify: Wh | ite |
| 15-0 | °2 hour "natu edical | Completed | 15. Decedent's Education (Specify only highest grade complete | ed) | (Give I | dent's Usual Occupa kind of work done du | | king | 16b. Kind | of Business In | dustry |
| 2121 | within 7 | | Elementary/Seconday (0-12) College | (1-4 or 5+) | | O NOT use retired) Chef | | | Fo | od Ser | vice |
| pui | filed vital Hyged other | To Be | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nar | | | | 1 |
| ıryla | ould be id Men marke matic | _ | Antonio Mazzeo 19a. Informant's Name/Relationship (Type, Print) | | 19b Mailir | ng Address (Street a | | ← Paola V | | | Code) |
| Ma Ma | d2shα althan n27is ertrau | | Rosa Mazzeo - Wife | | 165 | 6 E1kwood | Ct, Ann | apolis, | MD 21 | 409 | |
| Baltimore, Maryland 21215-0036 | ge 1 an nt of He t: If iten | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr | om State | emetery, cren | sition (Name of natory or other place | | Date | | tion - City or To | · |
| altin | mit. Pa bartme bortani r injury | | 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses | Ba. | | e Cremato . Name and Address | | 24/2012 hn M. Ta | | | |
| Ä | permi Depar Impor any ir | | Muglin , Robert | & | 240 | 147 Duke | of Gloud | ester S | t, Anr | | , MD 21401 |
| ~ | Physician/ | | 23a. Part 1. Enter the disease, or complications th shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition | at caused the death each line. | | er the mode of dying | | | rest, | | Approximate Interval Between Onset and Death |
| | Medical Examiner | | resulting in death) Due | to (or as a consequ | ence of): | | | | | | |
| | | iner | Sequentially list conditions, b. If any leading in immediate cause. Enter Underlying | to or as a conse ju | ence of: | | | | | | |
| | ecuted and I-transi | Examiner | Cause (Disease or linjury that initiated events C. | to (or as a consequ | ence of): | | | - | | | |
| 0 | icate be executed physician and s the burial-transit | edical I | d | | | | | | | | |
| 38760 | rtificate ling phy e as th | /Med | IF FEMALE: | outcome of pregnar | nev | | | | | - | |
| . Box 68 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/M | in the past 12 months? | ve Birth 2 Fetal regnant at time of d | I death 3 | Ectopic pregnancy Other (specify) | | | 230 | d. Date of deliv Month | Day Year |
| ls, P.O. | ires that th signed by Id be detaα | by | Part II. Other significant conditions contributing t | o death but not resu | ulting in the u | inderlying cause give | en in Part I. | | | | ne cause of death? |
| cord | aw requas beer 2 shou | Completed | | | | | | 24a. Was | psy | prior to co | psy findings available impletion of cause of |
| Re | The kicate h | | OF AV | | | | | | 2 No | death? | 2 No |
| Vital | /sician s certif directo | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: | ☐ Inpatient 2 ☐ | ER/Outpatier | Otho | r: 4 Nursing F | lome 5. Resid | dence 6 🗆 | Other (Specifi | 1) |
| Division of Vital Records, | ding Phy h. After this funeral o | | 27. Manner of Death 28a. De | ' | 28b. Time of injury | 28c, Injury work | at | 28d. Describe h | | | / |
| visio | or Atten ifter dea Director: in by the | Certificate: | 3 Suicide 6 Could not be 28e. Pla | ace of Injury - At hor ilding, etc. (Specify) | | eet, factory, office | | 28f. Location (S City or Tov | | lumber or Rura | l Route Number, |
| Õ | ospital hours a uneral C | Medical (| 29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the | | | | | | | | |
| | thin 24 thin 24 the Fu | Me | (Check 2 Medical Examiner: On the only one) 3 Gertifying Nurse Praction 29b. Signature and title of certifier | er: To the best of my | knowledge, | death occurred at the | time, date and pl | ace, and due to th | ie cause(s) ar | nd manner as signed (Month, | tated. |
| 9 | 7 × 7 0 0 0 | | > Vater KOD | no lle | | 1)((| 364 | | 01 | 23/2 | 012 |
| | 50 | | 30. Name and address of person who completed on Peter Graze 2003 | ause of death (Item Medical | 23a) (Type, F | | olis, MD | 21401 | | | |
| | Sta | | | , Registrar's Signat | ure . | | | 2,101 | | | |
| | Registr | ar | | were B | . 44 | 100 | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 201^{Ye}2 Month Physician/ David James Martin 12:48 AM January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs, last birthday) **Funeral** 046-28-5082 74 **Director** 1 🎇 M 2 🗆 F 1937 Connecticut Jan. 30, Usual Residence of Decede 28a-f show aţ 10a. State 10c. City, Town or Location with the Maryland Director Venice must be notified FLSarasota 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö items 23a Funeral # 205 USA 34285 1164 Bird Bay Way 12. Was Decedent Ever in U.S. 1958death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Examiner Armed Forces? 1958.

1 X Yes 2 No 1965

If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after White 1 ☐ Yes 2X No Specify: Specify: "natural", 3 XWidowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Stratford Board of I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Teacher Education Realtor/ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other 2 Alice Driscoll Oliver Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 752 Minstrel Court Millersville, MD 21108 Julie Doherty / Daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Metro Crematory, INC. 1 Burial 2 XCremation 3 Removal from State January 23, Baltimore, MD 2012 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licens Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final Obstructive Physician/ hronic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to or as a consequence of cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or injury that initiated events and I-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 the 38 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death g Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဂ္ဂ 1 Inpatient 2 🗌 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) injury 1 Natural 5 \square Pending 2 No 1 Yes Investigation Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse-Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

58510 21401

29d. Date signed (Month, Day, Year)

2001 Medical Parkway, Annapolis, MD

31. Date filed (Month 5 2012

29b. Signature and the of certifier

Registrar

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For | State o | of Marylan | | | | nd Mental Hy | giene | | 01511 |
|----------------------------|--|--------------|--|---------------------------|---|-----------------|---|----------------------|---|---|-----------------------|--|
| | | | State Registrar | Local | | Cer | tificate of L | Death | 0.0-4-460- | Reg. No. | 112 | 14541 |
| | Physicia | n/ | Decedent's Name (First, Middle, ROBERT | E. | MIN | TON | | | 2. Date of De Month JAN • | Day 30 | Year 2012 | 3. Time of Death 10:42 P ^M |
| | Medic Examin | - | 4a. Facility Name (if not institution, | | | ION | 4b. City, Town, o | r Location of E | | 4c. County | | 1 10:42 F |
| أنمد | LAMITHI | GI | 12227 LOIS STR | | | | BISHOP | VILLE | | W | ORCES' | TER |
| | Funeral | | | 6. Sex 1 ፟፟ M 2 ☐ F | 7. Age (In yrs. la | | If Under 1 Year Months Days | If Under 24 Hours | Min. 8. Date of Bin (Month, De OCT • 3 | th ay, Year) | 9. Birthp Count | lace (State or Foreign try) YLAND |
| | Director | | 218-05-7498 Usual Residence of Decedent | | 91 | Yrs. | | | OCT. 3 | ľ, 1920 l | MAR | YLAND |
| | and show fat | ō | 10a. State 10b. County | | 10c. City | , Town or Loc | cation | | | | 1 | 0d. Inside City Limits |
| | Maryl 28a-f otifiec | Director | MARYLAND WORCE: | STER | | BISHOP | VILLE | | | | | 1 ☐ Yes 2 🛣 No |
| | th the | | 10e. Street and Number | | | | 10f. Zip Code | - | | 10g. Citizen of | | try? |
| • | ms 2; | Funeral | 12227 LOIS STRI | | edent Ever in U.S | 13 V | 2181: | | ? (Specify Yes or No- | USA 14 Bac | e - Americ | an Indian |
| ٥ | er dez or ite miner | by F | 1 Never Married 2 Marri | Armed Fo | orces? 2 XNo | l II | Yes, specify Cuba | an, Mexican, P | uerto Rican, etc.) | Blac | ck, White, e | |
| 3 | ural", ural", | ted | 3 X Widowed 4 Divorced | If Yes, Giv Year or Di | | | Yes 2 XNo | | | Specify | WH: | ITE |
| 2 | 72 hol 1 "nat ledica | Completed | 15. Deceden (Specify only highes | T** | | Give F | lent's Usual Occup kind of work done (O NOT use retired) | during most of | working | 16b. Kind of B | usiness Inc | dustry |
| 9500-61212 | vithin jiene. er thar the N | | Elementary/Seconday (0-12) 12 | College (1 | I-4 or 5+) | ı | MILKMAN | | | MANUFA | ACTUR: | ING |
| g | be filed within 72 hours after death with the Maryland ental Hygiene. Yead other than "hatural", or items 23a or 28a-f show ked other than "hatural", or items 2a or 28a-f show ic event, the Medical Examiner must be notified at | Be C | 17. Father's Name (First, Middle, La | ast) | | | | 18. Mother's | Name (First, Middle | , Maiden Surnam | e) | |
| yla | should be fill and Mental is marked of aumatic eve | 욘 | HOWARD | MINTON | | | | EDN | | COLE | | |
| Maryland | 2 shou Ith and 27 is m | | 19a. Informant's Name/Relationsh PAMELA S. DUTT(| | ER | 1 | | | or Rural Route Number SHOPVILLE, | | - | |
| | and Hea tem | | 20a. Method of Disposition | · | 20b. P | lace of Dispo | sition (Name of | | Date | 20c. Location | | |
| Ē | Page 1 ment of ant: If it ury or o | | 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) | 3 ☐ Removal from pecify) | Julia | | natory or other place PARK CEM | | /6/12 | BALTIMOR | RE, M | ARYLAND |
| Baltimore, | permit. Page 1 Department of Important: If i any injury or once. | | 21. Signature of Funeral Service Li | cense | 0 | | . Name and Addre | - | HOME CE | TDWITTE | י דער | 10075 |
| _ | go = e o | | 23a. Part 1. Enter the disease, or | WHOV | Two d the deat | | | | HOME, SE | | , DE. | Approximate |
| | | | shock, or heart failure. List o | nly one cause on ea | ach line. | | | | | 11631, | | Interval Between Onset and Death |
| | nysician/ Medical | | disease or condition resulting in death) | a. Due to | (or as a consequ | ience of): | lan. | ynd. | vemy | | - | - |
| | Examiner | | Convertible list and distance | . / | 491 |) | | | | | | |
| | - = | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to | (or as a consequ | teriče vij. | | | | | 13 | |
| | ecutec and -trans | xan | Cause (Disease or linjury that initiated events resulting in death) Last | c. Due to | (or as a consequ | uence of): | | | | <u> </u> | -+ | |
| _ | be e | dical | , | | | | | | | | : | |
| 3/60 | vraquires that the death certificate I been signed by the attending phys should be detached for use as the | Medi | | _ u | | | | | | | | |
| χ × | th cert tendir or use | ian/l | 23b. Was decedent pregnant in the past 12 months? | 1 Live | | al death 3 | Ectopic pregnan | су | | | ite of delive | ery Day Year |
| 20 | e deal the at thed fo | Physician/Me | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 ☐ Preg 9 ☐ Unk | gnant at time of on nown | death 5∟ | Other (specify) | | | IVIC | | Day Total |
| J. | that the | | Part II. Other significant condition | ns contributing to | death but not res | ulting in the u | nderlying cause gi | ven in Part I. | 23e. Did | tobacco use cont | ribute to th | e cause of death? |
| _ S | puires l en sign uld be | ed b | - | - | | | | | _ 1□ | Yes 2 No | 3 🗌 Prot | oably 4 🗆 Unknown |
| Division of Vital Records, | aw rad as bee 2 sho | Completed by | | | | | | | 24a. Was | psy | prior to co | osy findings available mpletion of cause of |
| ā: | Th- Is | Con | | | | | | | | ormed? 2 No | death? 1 Yes_ | 2 🗆 No |
| ta | sician certifi rector | Be (| 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | 1 | 5D/0 / // | l Ott | | (Check only one) | • | <i>(</i> 0 : <i>(</i> | |
| <u> </u> | y Physer this eral di | e: To | 27. Manner of Death | 28a. Date | | 28b. Time of | 28c. Inju | y at | ing Home 5 Pres 28d. Describe | how injury occur | | |
| on | anding sath. or: Afte | ficat | 1 Natural 5 Pendin 2 Accident Investig | gation | nth, Day, Year) | injury | M 1 L | k? ÌYes 2 ☐ N | 0 | | | |
| NSI NSI | or Atter fter de irecto n by ti | Certificate: | 3 ☐ Suicide 6 ☐ Could I 4 ☐ Homicide determ | ined 28e. Place | e of Injury - At ho ling, etc. <i>(Specify</i> | | eet, factory, office | | 28f. Location City or To | (Street and Numb wn, State) | er or Rural | Route Number, |
| ٥ | To the Hospital or Attending Physician: The law raquires within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be | | 29a, Certifier 1 Certifying | Physician: To the | hest of my know | ledge, death o | occured at the time | e, date and pla | ace, and due to the c | ause(s) and manr | er as state | d. |
| | n 24 h | Medical | (Check 2 Medical E | xaminer: On the ba | sis of examination | n and/or invest | tigation, in my opin | on, death occu | urred at the time, date nd place, and due to t | and place, and du | e to the car | use(s) and manner stated. |
| | To the To the Complete Complet | | 29b. Signature and title of certifier | Λ | | | 29c. Licens | | | 29d. Date signe | d (Month, i | Day, Year) |
| | | | M | 1 | | | 1400 | 5624 | | 02 | -0% | 2-12 |
| | 8 | | 7-1 | who completed cau | | 23a) (Type, F | MA Com | 10:b. | Blux Ro | OZ ran M | 7 2 | 4811 |
| | Sta | e | 31. Date filed (Month, Day, Year) | 32. F | Registrar's Signa | | | 7 | VIII CE | 1-47111 | | 0.7 |
| | Registra | | FEB 0 2 20 | 12 Send | M. B. | Man | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Day 1 2012 9:00A M Marvel Medical Anna 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Wicomico Nursing Home If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) **Director** 1 □ M 2 🔀 F 222-16-3477 88 9-4-1923 New York Usual Residence of Deced f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ed other than "natural", or items 23a o by Funeral 709 W. Morris Leonard Road 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Meni Important: If item 27 is marke any injury or other traumatic Twilley Edna Graham Stanford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21804 709 W. Morris Leonard Road, Salisbury, Maryland Tim Church - Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Crematory of Delmarva 2-2-2012 4 Donation 5 Other (Specify) Delmar, Delaware 21. Signature of Furjeral Service Lice 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or completations that caused shock, or heart failure. List only one cause on each line. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physicun/ DEMENTIA disease or condition resulting in death) 5400VS Medical Due to (or as a consequence of): **Examiner** 104000 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence on). use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day 5 Other (specify) Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has L 2 No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, 24 hours a

Registrar DHMH 17 Rev 06-2011

State

To the I within 2

Medical

29a. Certifier (Check

only one) 29b. Signature and title of certifier

on ha rela

Date filed (Month, Day, Xear)

DR. USHA NATESAN.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

1415 -5. DIVISION ST,

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

SALISBURY,

29d, Date signed (Month, Day, Year)

Fibruary

15+ 2012

29c. License number

DU51359

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year Mary P. McEachin 2012 07 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation + Nursing Ctr comico isburo If Under 1 Year 8. Date of Birth (Month, Day, Year) Oct 3, 1925 Birthplace (State or Foreign Country)
 MD If Under 24 His **Funeral** 7. Age (In yrs. last birthday) 1 M 2 F Hours Months Min 240-36-7954 **Director** 86 Usual Residence of Decedent shov or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 ☐XYes 2 ☐ No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Indoctant: If them 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be Funeral 634 Arthur Street 21801 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 African-If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify Completed McEachin American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Teacher Public Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Plummer India Buffaloe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter McEachin/husband 634 Arthur St., Salisbury, MD 21801 Baltimoré, Mary 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory 01/28/2012 Hebron, MD Signature of Funeral Service License 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ementra disease or condition resulting in death) -610 Medical Due to (or as a consec ence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burnal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Dav Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 21 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 V. No မ 1 Yes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contributing Nurse Prantianer: To the best of my knowledge, due to commed at the time, date and place, and due to the cause(s) and manner as utated. (Check only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 23 12 OTC Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury, Mid 21804 Civie Tollows Borodulia 200 and 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State

DHMH 17 Rev 7/2009

Registrar

26

| | 110 | ase Type or Pr | | | | | | | | | _ | ie. | |
|-------------------|---|--|-------------|----------------------------|-------------------|---------------------|---|----------------------|--------------------------------|------------------|-------------------------------|----------|--|
| | For State | State of M | iaryiai | | | te of E | | na iv | ental Hy | | 201 | 2 | 01.51 |
| | Registrar 1. Decedent's Name (First, Midd. | le, Last) | | | rtmod | 10 07 2 | Journ | | 2. Date of D | Reg. No eath | 0. / | | 3. Time of Death |
| n/ al | Trach H | Huu Nguyen | | | | | | | Januar | y 2 ^D | , 201 ^x | ear 2 | 8:10P |
| er | 4a. Facility Name (if not institution | | | | _ | | Location of | Death | | 40 | c. County of | | 1 1 |
| | 800 Selby Heig 5. Social Security Number | | ne (In vrs. | last birthday) | 4 | dgewa ler 1 Year | ter I If Under 24 | 4 Hrs. | 8. Date of B | irth | | | rundel place (State or Foreig |
| | 567-87-6881 | l , | 78 | Yrs. | Month | s Days | Hours | Min. | (Month, D | ay, Year) | | Cour | ntry) |
| _ | Usual Residence of Decedent 10a. State 10b. County | | 1100 C | ty, Town or Lo | nation | | | | Ju1y | 2, 1 | 933 | | etnam 10d. Inside City Limit |
| Director | | Arundel | 100.0 | Edge | | r | | | | | | | 1 Tes 2 💢 N |
| | 10e. Street and Number | Arunder | | Duge | | ip Code | | | | 10g. C | itizen of Wha | at Cou | ntry? |
| Funeral | 800 Selby Heigh | nts Drive | | | | 21037 | | | | U | SA | | |
| Š | 11. Marital Status 1 □ Never Married 2 🛣 Ma 3 □ Widowed 4 □ Divorce | If Yes, Give | | | If Yes, sp | ecify Cuba | ispanic Origii n, Mexican, Specify: | n? (Spec Puerto F | cify Yes or No Rican, etc.) | - | 14. Race - Black, Specify: | White, | , |
| anal | 15. Decede | ent's Education | | | | ual Occup | | | | 16b. l | Kind of Busir | ness/In | dustry |
| Completed | (Specify only high Elementary/Secondary (0-12) | completed) College (1-4 or | 5+) | life. L | OO NOT u | se retired) | during most o | of workir | g | | public | | |
| Be C | 17. Father's Name (First, Middle, | 3 years | | Poli | ce U | ffice | | - Nama | (First, Middle | | uth V | ıetı | nam |
| 0 | Dung Huu | | | | | | Dao | | | , ivialuell | Surriame) | | |
| | 19a. Informant's Name/Relations | ship (Type, Print) | | 19b. Mail | ing Addre | ss (Street a | and Number | or Rurai | Route Numb | er, City o | r Town, State | e, Zip (| Code) |
| | Karen L. Fisher | -Nguyen/ Wif | e | 800 | Se1b | y Hei | ghts I | Driv | e, Edg | ewat | er, Ma | ary. | land 21037 |
| | 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation | 3 Removal from State | е | Place of Disponentery, cre | matory or | other plac | | _ | ate | | ocation - Ci | | |
| | 4 Donation 5 Other (21. Signature of Funer Service) | (Specify) | K | alas C | | | | $\frac{1}{1}$ | | | | | Maryland al Home |
| | 21. Signature of Juderal Service | ricensee | | 2 | 2. Name . 2973 | Solon | nons ${ m I}_{i}$ | slar | d Rd. | Edge | as ru ewater | , M | D 21037 |
| | 23a. Part 1. Enter the disease, of shock, or heart failure. List | | | th. Do not ent | ter the mo | de of dyin | g, such as ca | ardiac o | respiratory a | ırrest, | | T | Approximate |
| | Immediate Cause (Final disease or condition | a. Eso Due to (or as | | age | al | <u>_</u> | and | _~ | ~ | | | | Interval Between Onset and Death |
| | resulting in death) | Due to (or as | a consec | uence of): | | | - ' | | | | | \top | 4. |
| 5 | Sequentially list conditions, | b. — | | | | | | | | | | + | Tmon |
| Examine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | a consec | luence on: | | | | | | | | | |
| | that initiated events resulting in death) Last | c. Due to (or as | a consec | juence of): | | | | | | | | \top | |
| | | d | | | | | | | | | | | |
| Me | IF FEMALE: | 1 | | | | | | | | | | | |
| Physician/Medical | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown | 2 Fet | aldeath 3 | Ectopi | | :У | | | | 23d. Date of Month | | ery Day Year |
| by P | Part II. Other significant condit | ions contributing to death | but not re | sulting in the | underlyin | g cause giv | en in Part I. | | 23e. Did | tobacco | use contribu | te to t | ne cause of death? |
| ed | | | | | | | | | 1 🗆 | Yes 2 | □ No 3 | ☐ Pro | bably 4 🗆 Unknow |
| Completed | | | | | | | | | 24a. Was | s an opsy | 24b. Wer | e auto | psy findings availabl mpletion of cause o |
| Sol | | | | | | | | | 1 Yes | formed? | dea lo 1 | | 2 🗆 No |
| pe | 25. Was case referred to medical examiner? | Hospital: | | | | Othe | ace of Death | | | | | | |
| 2 | 1 Yes 2 No 27. Manner of Death | 28a. Date of inj | ury | ER/Outpatie | | DOA 28c. Injury | 4 ☐ Nurs | | ne 5 🔀 Res 8d. Describe | | | Specify |) |
| Cat | | ing (Month, Datigation | ay, Year) | injury | М | work 1 🗆 | ? Yes 2 \(\subseteq 1 | | | , | | | |
| Certificate: | 3 Suicide 6 Could 4 Homicide determ | | | | reet, facto | ory, office | , | 2 | 8f. Location City or To | | | r Rura | Route Number, |
| | | | | | | | | | | | | | |
| Medical | (Check 2 Medical | g Physician: To the best of Examiner: On the basis of g Nurse Practitioner: To the | examinatio | on and/or inves | stigation, i | n my opinic | n, death occi | urred at | the time, date | and place | e, and due to | the ca | use(s) and manner sta |
| Σ | only one) 3 L Certifyin 29b. Signature and title of certifie | | L Desi OI | rriy knowledge | | 9c. License | | ана ріа | e, and que ic | | ate signed (N | | |
| | > Porth A | Roben | ser | | + | 100. | 555 | 42 | | Ja | n 3 | 30 | 201 |
| | 30. Name and address of person | who completed cause of | death (Iter | n 23a) (Type, | | | | | Rd., A | nnano | nlie | MD | 21401 |
| | 30. Name and address of person | A THE COMPANION OR COMPANION OF THE | 4 | | | | CSCSa | LC I | , 111 | map. | ,,,,,,, | 111 | 21401 |

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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| | | For State | | State | e of Ma | arylan | | , | | | and M | 1ental Hy | giene | 20 | 10 | 01.5 | 1.5 |
| | | Registrar | e (Eirst Middle | . Last) | | | | ertificat | e or L | Jeath | | 2 Date of De | | o. <u>C</u> U | 16 | | |
| Medic | al | TODD | | W | | IN | EB | | | | | Month O | 28 | 7 0 | Year | 235 | |
| Examin | er | Anne Arun | del Me | dical C | enter | | | A: | nnapo | olis | | | | | Aru | ınde1 | |
| Funeral Director | | 216-23-6 | 705 | | _ | | | Months | | Hours | Min. | (Month, Da | ay, Year) | | Cour | ntry) | Foreign |
| Thysician Decolarity Name (First, Middle, Last) | | | | | | | | | | | | | | | | | |
| /ith the Ma 23a or 28a st be notif | ral Dire | 10e. Street and Num | nber | | | | | 10f. Zi | | | | | | | Vhat Cou | | |
| s after death v ral", or items Examiner mu | þ | 1 Never Marri | | ried Armed | Forces? 'es 2 1 Give | | S | If Yes, spe | cify Cuba | ın, Mexicar | n, Puerto I | | | Blac | k, White, | etc. | |
| ithin 72 hour ene. • than "natu he Medical | Complet | - ' ' | cify only highe | est grade comple | e (1-4 or 5 | +) | (G life | ive kind of wo e. DO NOT us | ork done d e retired) | | t of worki | ng | | | | | |
| be filed w lental Hygi rked other ic event, t | Be | | | ast) | | | | | | 18. Moth | | | Maiden | Surname | 9) | | |
| d 2 should alth and M 27 is ma er traumat | | | | | е | | | | | | | | | | | Code) | |
| Page 1 an nent of He ant: If iten ury or oth | | 1 🗌 Burial 2🏋 | Cremation | 3 ☐ Removal f | rom State | C | emetery, | crematory or | other plac | :e) | | | | | | | nd |
| permit. Departr Imports any inji | | 21. Signature of Fur | erfil Service I | icensee | | 1 | | | | | | | | | | | |
| hysician/ Medical | | shock, or hear Immediate Cause (F disease or condition | t failure. List o Final | only one cause o | n each line | A | C | | 1 | g, such as | cardiac o | r respiratory ar | rrest, | | | Approximate Interval Betwee Onset and De | een ath |
| Examiner | ner | if any, leading to im | mediate | b. —— | ` | | | | | | | | _ | | | | |
| executed ian and urial-transit | | Cause (Disease or i that initiated events | injury | c. Due | to (or as a | consequ | ence of): | | | | | | | | | | |
| physici | edica | | | d | | - | | | | | | | | | | | |
| e death certific the attending shed for use as | ıysician/Me | 23b. Was decedent in the past 12 n 1 Yes 2 | nonths? | 1 [1 [1 4 [F | ive Birth regnant at | 2 🗀 Feta | l death | | | Sy . | | | | | | | ar |
| uires that th signed by ald be detad | by | Part II. Other signifi | icant condition | ons contributing | to death bi | ut not resi | ulting in t | he underlying | cause giv | ven in Part | l. | | | | | | |
| The law requate has been page 2 shou | Complete | | | | | | | | | | | auto perfo | psy ormed? | , E | orior to co death? | ompletion of cau | ailable ise of |
| cian: lertifica | Be | examiner? | _ | Hospital: | | | | | | | th (Check | | | | | | |
| fing Physi J. After this c funeral dir | | 27. Manner of Death | 5 🗌 Pendir | 28a. D | ate of injur | у | 28b. Tim | e of ry | 28c. Injury work | 4 | | | | | | y) | |
| or Attencate after death | Certific | 3 Suicide | 6 Could | not be 28e. P | | | | | | Yes 2∟ | | | | | er or Rura | d Route Number | í |
| re Hospita n 24 hours le Funeral | dedical | (Check 2 | Medical E | xaminer: On the | basis of ex | amination | and/or ir | vestigation, ir | my opinio | on, death o | ccurred at | the time, date a | and place | e, and due | e to the ca | ause(s) and mann | ner stated. |
| To the within the composition of | ~ | 29b. Signature and t | title of certifie | 173 |){ |) 9 n | Xa | Ly 29 | | | f38 | | Ji | me | lar | 12920 | 12 |
| +10. | | 30 Name and addre | ess of person | 1 1 | cause of de | eath (Item | 23a) (Typ | pe, Print) | YEA | ISE | Hwy | ANA | IAP | OLIS | M | 0 2140 | (|
| | | 31. Date filed (Month | EB 01 | 2012 | 2. Registra | r's Signat | d. | park | 1 | _ | , | | | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Pratibha Pradip 3:00a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster 163 Alymer Court 8. Date of Birth (Month, Day, Year) 7 / 4 / 1 9 5 7 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Funeral Country) Kenya Months Days Hours 1 M 2 X F 54 Director 220-51-7453 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location Westminster 10d. Inside City Limits 10a. State 10b. Count death with the Maryland Director Carroll MD 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 "natural", or items 23a o Funeral USA 21157 163 Alymer Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 😾 No Specify: Specify: Asian Indian 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a Decedent's Usual Occupation 16h Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 72 | Elementary/Seconday (0-12) College (1-4 or 5+) filed within retail sales sales should be filed within and Mental Hygiene is marked other th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lalitaben Patel ည Ramanbhai Patel permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 163 Alymer Court, Westminster, MD 21157 Pradip Patel, husband Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, Carroll Cremation 2/9/2012 22. Name and Address of Facility M00741 Eline Funeral Home 21. Signature of Funeral Service Licensee 21074 934 S Main Street, Hampstead, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final an Physician Quari disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) and that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Hospital or Attending Physician: The law requires that the death of thours after death.
 Funeral Director: After this certificate has been signed by the atternal Director. Month Year Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, Completed should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? page 2 s performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 2012

Way 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fouad Abbas, M.D. 2411 W. Belvedere Ave. Baltimore, MD 21215

31. Date filed (Month Day Year)

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ January 2012 2:30 PM Potts Ε. Bertie Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Wicomico Salisbury Wicomico Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth **Funeral** Hours (Month, Day, Year) Director 1 □ M 2 🛛 F 216-74-1162 Maryland 9-16-1934 77 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Tes 2 X No MD Salisbury Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Ь Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r Funeral USA 21801 900 Booth Street hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces 2 X No þ 1 X Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 🗌 Widowed 4 🗌 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Malone Pauline Potts Ellis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5051 Stock Creek Lane, Salisbury, MD 21801 Clayton Wainwright - Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Wicomico Memorial Pk: 2-5-2012 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. Bounds Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licen 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused mock, or heart failure. List only one cause on each line. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ DEMENTA 5445 Medical resulting in death) Due to (or as a consequence of): Examiner 1040015 ASOVO Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). and that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of): tending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death for use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year been signed by the s should be detached q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available page 2 2 Medical Certificate:

To the Hospital or Attending Physician: The law requires that the dea h certificate be executed Division of Vital Records, P.O. Box 68760 s after death. filled in within 24 hours a

To the Funeral D

completely filled i

| | | | | autopsy performed? 1 Yes 2 No | prior to completion of cause of death? 1 Yes 2 No |
|---|--|---|---|---|--|
| 25. Was case referred to medical | | | 26. Place of Death (Chec | k only one) | |
| examiner? 1 Yes 2 No | lospital: | ER/Outpatient 3 🗀 [| OOA Other: 4 Nursing H | ome 5 Residence 6 | Other (Specify) |
| 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | 28b. Time of injury | 28c. Injury at work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury o | occurred |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At hor building, etc. (Specify) | ne, farm, street, facto | ry, office | 28f. Location (Street and I City or Town, State) | Number or Rural Route Number, |
| 29a. Certifier 1 Certifying Physical Examin | ician: To the best of my knowle | edge, death occurred and/or investigation, in | at the time, date and place, and my opinion, death occurred a | and due to the cause(s) and at the time, date and place, a | d manner as stated. and due to the cause(s) and manner stated |

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

1st 2012

| • | who who | D051359 |
|---|---------|---------|
| | | |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALISBURY, MO 21804 12 NOISING - 2 - 2141 DR. WHA NATES AN

31. Date filed (Month, Day, Year) State 2012 Registrar

only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Dorothy Barbara Pastuszak 2012 10:30 AM anuari Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Salisbury Retabilitation a Nursing C Salisburg 9. Birthplace (State or Foreign If Under 24 8. Date of Birth **Funeral** 7. Age (In yrs. 4 1 □ M 2 **K** F 488-16-7983 Months Days Hours 0872271919 **Director** 92 Missouri Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Civic Ave. 21804 LISA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give White 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. 12 <u>Accounting</u> Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Adolph Rudokas Eva Zitkus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Pastuszak/daughter 623 Hammond St., Salisbury, MD 21804 pern it. Page 1 and 2
Deportment of Health
Important: If item 2;
any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Calvary Cemetery 2/2/2012 4 Donation 5 Other (Specify) Memphis, TN 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association gompson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Il or Attending Physician: The after death. Director: After this certificate h Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Fractioner: To the best of my included about occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature 29d. Date signed (Month, Day, Year) 28767 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 200

Bordulia

32 Registrar's Signature

celio Jees

ine Ave

Salishy Md 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25, <u>2</u>012 Kalpesh Patel 11;00 a^M January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Wicomico 9258 Tournament Drive Delmar If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 153-90-7863 1**X** M 2 □ F 46 06/14/1965 India an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Wicomico Delmar 10f. Zip Code 10g. Citizen of What Country? Funeral 9258 Tournament Drive 21875 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify: Hindu Completed 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the 12 4 Convenience Store Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Natubhai K. Patel Shardaben N. Patel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9258 Tournament Dr., Delmar, MD 21875 item 27 Shilpa K. Patel/spouse Department of Health Important: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State Salisbury Crematory 1/28/2012 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee Name and Addres and Address of Facility
Loway Funeral Home Professional Association
Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition Onset and Beath Physician/ MU Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or se a consequence of) Cause (Disease or injury that initiated events resulting in death) Last To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No. 3 Probably 4 Unknown 1 \sum Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 2/X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1(Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and ti 29d, Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address/of CHAROUST SAUSBURY 6 BK 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 31 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 0745 David Calvin Polk January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 825 West Road Salisbury Wicomico If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Min. 214-52-0972 Months Hours 65 Director 1 🛛 M 2 🗆 F 10/22/1946 Maryland Usual Residence of Decedent shov 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f Maryland 1 Yes 2 X No Wicomico Salisbury 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21801 825 West Road Black death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 Married within 72 hours after Completed by Yes 2 X No Baltimore, Maryland 21215-0036 Black permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exar 1 Yes 2 X No Specify If Yes, Give 3 Widowed 4 A Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie Mae Armwood Ira Polk 19a. Informant's Name/Relationship (Type, Print)
Nelson Lee Polk/brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 681 West Main St., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 D cemetery, crematory or other place) Removal from State 1/31/2012 Donation 5 - Other (Spec Salisbury Crematory Salisbury, MD 21. Signature of Funeral Se Stewart Funeral Home by Holloway and Downey, P.A. 821 West Rd., Salisbury, MD 21801 Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause open the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate erval Betweer Onset and Death nmediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner sician and burial-transit Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the use as attending r IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? signed by the at d be detached for Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy perform 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Ceptifying Nurse Practitioner: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed Month, Day, Year) Z annewino 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THURIAS 100 15 LAWOU

Registrar

Date filed (Month, Day, Year)

JAN 31

gistrar's Signature,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | 1 - State of Maryland State of Maryland | | rtment of H tificate of D | | | ene eg. No. 20 | 112 | 04551 |
|----------------------------|---|--------------|---|--------------------|--|---------------------|--------------------------------------|------------------------|--------------------------|---|
| F | Physicia | n/ | Decedent's Name (First, Middle, Last) | | | | Date of Death Month | | Year | 3. Time of Death |
| | Medic | al | beatrice Kagsdale 4a. Facility Name (if not institution, give street and number) | | 4b. City, Town, or | Location of Death | 01 | 4c. County | 012 | 10:334 ™ |
| | Examin | er | Anne Arundel Medical Center | | Annape | | | 1 | | ındel |
| * | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last 1 ☐ M 2X F 84 | | if Under 1 Year Months Days | Hours Min. | 8. Date of Birth (Month, Day, 13 | | Count | ace (State or Foreign ry) yinia |
| | and show | lor | | Town or Loca | ation | | | | 10 | d. Inside City Limits |
| | 28a-f | Director | - | napo | | | | | | 1 ☐ Yes 2X No |
| | ith the | | 10e. Street and Number 1807 Bowman Dr. | | 10f. Zip Code | 401 | 10 | og. Citizen of W US | | ry? |
| | eath w | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. | 13. W | as Decedent of His | spanic Origin? (Spe | ecify Yes or No- | 14. Race | e - America | |
| Maryland 21215-0036 | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. | - 1 | Yes, specify Cubar Yes 2 No | | rican, etc.) | Specify: | k, White, e ${f B}{f J}$ | tc. Lack |
| 15-0 | 72 hou "natu edical | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give ki | ent's Usual Occupa ind of work done d | | ing | 16b. Kind of Bu | siness/Ind | ustry |
| 72 | vithin 7 jene. | | Elementary/Secondary (0-12) College (1-4 or 5+) 8th 0 | | NOT use retired) | signer | | Kar1to | n F1 | orist |
| nd | filed v tal Hyg d othe event, | To Be | 17. Father's Name (First, Middle, Last) | | | _ | ne (First, Middle, M | | | |
| <u>Na</u> | should be file n and Mental I 7 is marked o raumatic eve | ř | Raymon Logan 19a. Informant's Name/Relationship (Type, Print) | 401 14 77 | A 1 1 - (O) | | Edmond | | 7'- O | - 4-1 |
| | and 2 sho Health an tem 27 is i | 100 | | ` | g Address (Street a Whip Lai | | | | | 1.1 |
| ore, | e 1 and of Hea If item ir othe | | | | itien (dame of atory or other place | | | 20c. Location - | | |
| Baltimore, | t. Page rtment rtant: njury o | | 4 □ Donation 5 □ Other (Specify) Mem | oria | l Garde | $ns \mid 1-2$ | | Annapo | | Md. |
| Bal | permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other? | 9 | 21. Signature of Funeral Service Licensee Lavry B, Reese | | name Ræss 922 Fore | | | | | 21401 |
| r | | | 23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. | Do not enter | the mode of dying | , such as cardiac | or respiratory arres | t, | | Approximate Interval Between |
| - | Medical | | Immediate Cause (Final disease or condition resulting in death) | | 4 | | | | | Onset and Death |
| Same? | Examiner | | - Due to (or as a consequent | ce of): | | | | | | |
| | ed nsit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | ce of): | | | | | | |
| | cate be executed physician and the burial-transit | | that initiated events c. The properties of the | ce of): | | | | · | | |
| 90 | ate be physici the bu | dical | d | | | | · | | | |
| 687 | eath certifica attending p | n/Me | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance | | | | | 23d, Dat | e of delive | ry |
| Box | e death the atter | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | | Other (specify) | <i>y</i> | | Mor | nth | Day Year |
| P.O. | requires that the der been signed by the s should be detached | y Ph | Part II. Other significant conditions contributing to death but not resulti | ing in the ur | iderlying cause give | en in Part I. | 23e. Did tob | acco use contr | ibute to the | e cause of death? |
| ds, | quires en sign ould b | ted k | | | | | 1 □ Ye | s 2 No | 3 Prob | ably 4 🗆 Unknown |
| ecor | The law re ate has be page 2 sh | Completed by | | | | | 24a. Was an autopsy perform | / P | | sy findings available npletion of cause of |
| <u>~</u> | Physician: The r this certificate h sral director, page | Be Co | 25. Was case referred to medical | | 26. Pla | ce of Death (Chec | 1 Tes 2 | No 1 | ☐ Yes | 2 🗆 No |
| Σ, | hysicia his cer al direc | To B | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EF | | : 3 🗆 DOA Othe | r: 4 Nursing Ho | ome 5 Resider | nce 6 🗆 Othe | er (Specify) | |
| n of | ding P th. After tl funera | cate: | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) | Bb. Time of injury | 28c. Injury work M 1 🗆 | | 28d. Describe how | v injury occurre | ed | |
| Division of Vital Records, | al or Attending Pl s af er desth. I Drector Affer the ed ir by the funera | Certificate: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify) | e, farm, stree | et, factory, office | | 28f. Location (Stre City or Town, | | er or Rural | Route Number, |
| Ω | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical | 29a. Certifier 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination at | nd/or investi | gation, in my opinio | n, death occurred a | it the time, date and | place, and due | e to the cau | se(s) and manner stated. |
| | To the within To the compl | Σ | only one) 3 Certifying Nurse Practitioner: To the best of my 29b. Signature and title of certifier | TIDWIEGGE, (| 29c. License | | | d. Date signed | | |
| | | | I ghen Date D.o. | | | 70482 | _ <u> </u> | 1-12 | | |
| | of B | | 30. Name and address of person who completed cause of death (Item 23 | | | Pallno | L A | nearl | , > | MA |
| | Stat Registra | | 31. Date filed (Month, Day, Year) 1 2012 32. Registrar's Signature | | ake | , | 7 11: | | * | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04552 for State Registrar Certificate of Death 3. Time of Death 2:05 p 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 31, 2042 Physician/ Stanley Rossman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Golden Living Center 8. Date of Birth (Month, Day, Y Jun 16, Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min Day, Yea 705-12-4328 Months Hours Maryland 93 1 XM 2 □ F 1918 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director Westminster Carroll Maryland 1 Yes 2 No 28a-f 10f. Zip Code 10g. Citizen of What Country? ō must be 21157 Funeral 533 Baltimore Blvd 23a USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or ite Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc ò 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: white Completed 3 ¥Widowed 4 ☐ Divorced WWII Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4 or 5+) Maryland Correctional Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o Florence Roth 2 Charles Rossman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health al Important: If item 27 is any injury or other trat 1214 Cape Sable Drive, Westminster, MD 21158 Robert Rossman, son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/1/2012 Winfield, MD Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home Signature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart failure. List only one cause on, ach line. Approximate Interval Between Onset and Death Physician/ lumonia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Physician/Medical Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2
Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Pregnant at time of death P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Certificate: To Be Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 1 X Natural 5 Pending 2 🗌 No Accident Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined Medical 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Division of Vital Records,

State Registrar 29h Signature and title of certifie

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) John W. Middleton Mo 32. Registrar's Signature

record

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Registra DHMH 17 Rev 1/2001

OCME 2006

State

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

acke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Helen C. Roe 1:50 P 2012 Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 505 Red Oak Drive Severna Park Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday. If Under 24 Hrs Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth **Funeral** Months Days 219-32-7216 77 **Director** 1 M 2 K F 11,18 Maryland Usual Residence of Decedent 28a-f show with the Maryland at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director notified MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 505 Red Oak Drive 21146 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Force Black, White, etc 1 Never Married 2 Married by Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the Ith and Mental Hygien
27 is marked other the traumatic event, the 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Skelton Helen May Dunbar Page 1 and 2 should? ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Winfield Scott Roe III/ Son 505 Red Oak Drive Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 4 Donation 5 2012 Metro Crematory, INC. Other (Specify) Signature of Funeral Sorvice to Barranco & Sons, 495 Ritchie Hwy, Severna Park Funeral H Severna Park, MD 21146 P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ disease or condition 0 Medical resulting in death) consequence of) Examiner Sequentially list conditions, Examine Due to or as a consequent of it my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4. Unknown Completed 1 Yes 2 No 3 Probably 4 peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No 1 Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital or within 24 hours at To the Funeral D

State Registrar

Victor Playner, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1509 Ritchie Hwy. gistrar's Signature

(Check only one

29b. Signature and title of certifier

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28686

Arnold, MD 21012

29d. Date signed (Month. Day, Year,

12

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 26, 27 per MD g943 9/10/13 TRT State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** DAVAG RNEST 21,2012 ORMAN January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TIMORE 1405PITAL BALTIMOR BAL SECOURS 130 N 8. Date of Birth (Month, Day, Year) Feb. 28, 1 Birthplece (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1X M 2□ F 1959 Virginia Yrs. Feb. Director 217-74-3182 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No MD Wicomico Salisbury Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ō 23a USA 21801 27485 Edgewood Circle death Funeral 14. Race - American Indian Itams 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1K Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Perdue Farms, Inc. 8th Laborer other permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg.
Important: if Item 27 is marked other
any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Josephine Trader Adolphus Phillips 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27485 Edgewood Circle - Salisbury, Maryland 21801 Josephine Phillips/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □ Removal from State *4 □Donation 5 □ Other (Specify) Springhill Memory Gardens 01/30/2012 Hebron, Maryland 21. lign ture of Funeral Service Licensee 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel- 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of) **Examiner** EART ALLURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Dissued or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner death certificate be executed as the burial-transit TRIOVE CULAR attending physicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 Fetal death Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o. the 9 Unknown The law requires that the 9 Hunknown ۵ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, YNDROMS 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No ONN Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RONIC 24a. Was an autopsy performed? has ESS EN ENSION TIAL 1 ☐ Yes 2/1/10 Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛣 No Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Xatural 5 Pending Injury 1 Yes 2 No death. investigation 2 Accident after death Director: filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral (To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatula and title of certifier 29c. License number January 21, 2012 2000 WET BALTIMORE Vou OUN, of death (Item 23a) (Type, Print) BON SECOUR 9 HOSPITAL BALTIMORE, MD. 21223 SOA SYLVANUS 32. Registrar's Signature 31. Date filed (Month State Barka Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | - | For State Registrar | State of Mary | | ertificate of D | | | eg. No. 2 | 012 | 04556 |
|--------------------------------|---|-------------------|---|--|-----------------------------|--|---------------------------------------|--------------------------------------|-----------------|--|--|
| | Physicia | n/ | 1. Decedent's Name (First, Middle, La | , | | 1 | | 2. Date of Deat January | | O 1 ^{Year} | 3. Time of Death |
| | Medic Examin | al | William 4a. Facility Name (if not institution, give | L. | Smit | T | Location of Death | January | | ty of Death | 11:10 PM |
| | Examin | er | Genesis Health C | | | LaP1a | | | | arles | |
| | Funeral Director | | 074-22-0764 | TTM 2 TE | yrs. last birthda Yrs | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 05/11/ | Year) | 9. Birthpl Co <i>unti</i> Ne | ace (State or Foreign ry) W York |
| | nd thow at | 'n | Usual Residence of Decedent 10a, State 10b. County | 10 | c. City, Town or | Location | | | | 10 | d. Inside City Limits |
| | Maryla 8a-f s tified | rect | Maryland Charles | | White F | lains | | | | | 1 ☐ Yes 2XX No |
| | with the I s 23a or 2 ust be no | Funeral Director | 10e. Street and Number 4774 Desert Ros | e Court | | 10f. Zip Code 2069 | 95 | 1 | | of What Count | ry? |
| 036 | e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by | 11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever Armed Forces? 11/12 Yes 2 No If Yes, Give Year or Dates. | in U.S. 1 | 3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🙀 No | | cify Yes or No- Rican, etc.) | | ace - America lack, White, e ify: B1 | |
| Baltimore, Maryland 21215-0036 | iin 72 hou e. han "natu e Medical | Completed | 15. Decedent's Elementary/Seconday (0-12) | | (Gi | cedent's Usual Occupi ve kind of work done o . DO NOT use retired) | ation Juring most of workii | ng | | Business Ind | ĺ |
| 2 | d with lygien ther th nt, the | Be C | | 5+ | Educ | ator | 40. Mathada Nasa | | | 1 Gove | rnment |
| anc | ould be file d Mental H marked o | 고 교 | 17. Father's Name (First, Middle, Last) $Robert T.$ | Smith | | | 18. Mother's Name Pear1 | Nabor | | me) | |
| ary | should and Me rs mar raumati | | 19a. Informant's Name/Relationship (| Type, Print) | 19b, M | ailing Address (Street a | and Number or Rura | l Route Number, | City or Town | , State, Zip C | ode) |
| Σ, | of Health and Ment of Health and Ment fitem 27 is marked r other traumatic | | Lisa Gardner / D | | | 11 Royal F | | | | | |
| imore | permit. Page 1 a Department of H Important: If ite any injury or ott | | 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec | Removal from State | cemetery, o | sposition (Name of crematory or other place rematory | 2/1/2 | 2012 | Edgewa | | aryland |
| Balt | permit. Depart Import any inj | | 21. Signature of Juneral Service Licen | 6 | | 22. Name and Addres | | | | | |
| | M DEZ | | 23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final | nplications that caused the | death, Do not | | | | | | Approximate Interval Between Onset and Death |
| 7 | Medical | | disease or condition resulting in death) | a. Burings Due to (or as a co | insequence of): | | | | | - | |
| | Examiner | ner | Sequentially list conditions, if a y, back as to in rediction cause. Enter Underlying Cause (Disease or linjury | b. Sepsis | | docy to | UTI | | | | |
| | and transit | Examiner | that initiated events | c. Due to (or as a co | inceditance of: | | | | | | |
| 0 | certificate be executed nding physician and use as the burial-transit | | resulting in death) Last | Due to (or as a co | insequence on. | | | | | | |
| 3760 | ificate ig phy as the | Medi | IE ECMALE: | - u | | | | | | | |
| Box 6 | atte of | Physician/Medical | IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2'☐ No 9 ☐ Unknown | 23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown | Fetal death | 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _ | sy | | - 1 | Date of delive Month | ry Day Year |
| s, P.O. | v requires that the described signed by the should be detached | ρ | Part II. Other significant conditions | contributing to death but n | not resulting in the | ne underlying cause giv | ven in Part I. | | es 2 No | | e cause of death? |
| Division of Vital Records, | siclan: The law requires certificate has been sign irector, page 2 should be | Completed | | | - | | | 24a. Was a autops perfor | med? | | sy findings available inpletion of cause of |
| a | lan: Th | BeC | 25. Was case referred to medical examiner? | | | 26. PI | ace of Dea (Check | | 2 1/21 NO | 1 🗆 165 | ZĄZI NO |
| ٥ | Physic this ce al direc | 은 | 1 ☐ Yes 2 ☑ No 27. Manner of Death | | | atient 3 DOA Othe | 4\L Nursing Ho | me 5 🗆 Reside | | | |
| o u | nding Fath. : After e funer | icate | 1\(\sqrt{2}\) Natural 5 \(\sqrt{2}\) Pending 2 \(\sqrt{2}\) Accident Investigation | 28a. Date of injury (Month, Day, Ye | ear) 28b. Tim inju | y work | yat (? Yes 2 □ No | 28d. Describe ho | w injury occi | urred | |
| Division | al or Attending Physician: s after death. I Director: After this certific d in by the funeral director, | Certificate: | 3 Suicide 6 Could not 4 Homicide determined | be 290 Place of Injuny | - At home, farm, pecify) | street, factory, office | | 28f. Location (St City or Town | | nber or Rural | Route Number, |
| _ | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu | Medical | (Check 2 Medical Exam | ysician: To the best of my niner: On the basis of exam rse Practioner: To the bes | nination and/or in | vestigation, in my opinio | on, death occurred at | the time, date an | id place, and i | due to the cau | se(s) and manner stated. |
| | To the within comp. | | 29b. Signature and title of certifier | kau | | 29c. Licenso | | | | ned (Month, E | |
| 7 | HOH | | 30. Name and address of person who | completed cause of death | h (Item 23a) (Typ | e, Print) Kira | ndeep Kau | ir MD | np 2 | 1401 | |
| | Sta Registr | | 31. Date filed (Month Pay Year) 1 2 | 13.0.01 | Signature | bare | · · · · · · · · · · · · · · · · · · · | -1/ | | | |

DHMH 17 Rev 7/2009

12-01168 Harry Snyder

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2012 04557

| | | | I-ForState Ammended #4C Per ME WSH C.Co | . Certific | ate of | Death | | 7.5 | Reg. No | <u> </u> | 2 0 4 0 0 |
|--|---|----------------|---|-------------------|---------------|---|--------------------|--|-------------|----------------------------------|--|
| Phy | sicia | ın/ | Decedent's Name (First, Middle,Last) | | | | | 2. Date of De Month | eath Day | Year | 3. Time of Death |
| andical Ex | amiı | | Harry Craig Snyder | | | 07 T | Landing of | February | | c. County of Death | 1208 hrs |
| | | | 4a. Facility Name (if not institution, give street and number) 917 Emory Church Road | | 45 | . City, Town, or Upperco | Location of | Death | | | nty Carroll |
| From | | | • | (In yrs. last bir | rthday) | If Under 1 Yea | r If Under | 24Hrs. 8. Date of I | | 1/DD/YYYY) 9. Birti | |
| Fune Direc | | | 213-58-2714 1X M 2 F | 59 | • • | Months Day | | Min. 09/0 | | 952 Foreign | Maryland |
| | A. | | Usual Residence of Decedent 10a. State 10b. County 1 | Oc. City, Town | or Locatio | n | _ | | | | 10d. Inside City Limits |
| | ow any | | Maryland Carroll | Upper | | • | | | | | 1 Yes 2 No |
| yland | ZSa-f show I at once. | 흱 | 10e. Street and Number | | | 10f. Zip Code | | | 10a. Ci | tizen of What Coun | itry? |
| ı the Mar | items 23a or 28a-f sho ist be notified at once. | Dire | 917 Emory Church Road | | | 21155 | | | - | ited Stat | es |
| death with | nust be n | Funera | 11. Marital Status 1 Never Married 2 Married Armed Forces 1 Types 2 | ver in U.S. | If Yes | s, specify Cubar | , Mexican, | n? (Specify Yes or I Puerto Rican, etc.) | 10- | 14. Race - Americ White, etc. | |
| after : | iner, | b F | 3 Widowed 4 Divorced If Yes, Give Year or Dates: | | | res 2 X No | | | Lini | Specify: | |
| hours | Exam | | 15. Decedent's Education (Specify only highest grade comp | | during mos | t of working life | | ind of work done use retired) | 160. | Kind of Business/Ir | naustry |
| 36 in 72 | han | plet | Elementary/Secondary (0-12) College (1-4 or 5-4 | " f: | irefi | ghter | | | eı | mergency | services |
| d with | other than "natura the Medical Exami | Completed | 17. Father's Name (First, Middle, Last) | | | | 18.Mother's | Name (First, Middle | , Maide | n Surname) | |
| 21215-0036 All be filed within 7 Mental Hygiene | narked o | BeC | Harry Calvin Snyder | | | | Ade] | lle Lecomp | ote | | |
| O ₹ 5. | tic is | | 19a. Informant's Name/Relationship (Type, Print) Frances E. Snyder / wife | | | | | per or Rural Route N Road Uppe | | | |
| Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M | tant: If item 27 is n or other traumatic | | 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from Stat | crema | tory or othe | on (Name of cer or place) Cemeter | metery, | Feb. 13, | | Location - City or ampstead, | Town, State Maryland |
| Iting Partiment | y or | - 14 | 4 Donation 5 Other Specify: 21. Signature of Funeral Service Live ee | | 22. Na | me and Address | of Facility | E ine Fu | nera | al Home | |
| Den B | | -);} | Alan C. Furn | 01072 | 934 | 4 South | Main | Street H | lamp: | stead, MD | 21074 |
| Physic | ian | | 23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. | ne death. Do n | ot enter the | mode of dying, | such as ca | rdiac or respiratory a | rrest, sł | nock, or heart | Approximate Interval Between Onset and |
| /Medi Exami | _ | | Immediate Cause (Final disease a. Hypertensi | ve Athe | eroscl | lerotic | Cardi | ovascular | Di | sease | Death |
| LAdiiii | IICI | | or condition resulting in death) Due to (or as a consec | | | | | | | | |
| | | <u>.</u> | Sequentially list conditions, if any, leading to immediate Due to (or as a consec | uence of): | | | | | | | |
| | | | cause. Enter Underlying Cause (Disease or injury that initiated | | | | | | | | |
| ted | ınsit | Exa | events resulting in death) Last Due to (or as a consected d. | (uence of): | | | | | | | |
| 60, ate be executed | the attending physician and ed for use as the burial - transit | Medical | ▼ UNPENDED | pt.II, | 27, pe | r me,g9 | 26 4-1 | 19-12 sm | | | |
| 760, icate be | physi the bu | | IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the | of pregnancy | | | ¬ | | 2: | 3d. Date of delivery | |
| 68 | nding se as | iä | past 12 months? | | | Ideath 3 er (Specify) | Ectopic | pregnancy | | Month D | ay Year |
| Box 687 e death certific | e atte | Physician/ | 1 Yes 2 No 9 Unknown 9 Unknown | | J Otne | er (Specify) | | | | | |
| P.O. I | >는 | | Part II. Other significant conditions contributing to death | but not resultir | ng in the un | derlying cause o | given in Par | | | | the cause of death? |
| □ ties th | as been signed to should be deta | ğ ğ | <u>Obesity</u> | | | | | | 'es 2 [| | ably 4 Unknown |
| rds . | should | ete | | | | | | | opsy | prior to c | topsy findings available ompletion of cause of |
| eco he law | 271 | Completed | - | | | | | | formed? | | s 2 No |
| Z = . | certificate ector, page | | 25. Was case referred to medical | | | 26.Place | of Death (| Check only one) | | | |
| Vita | 을 분 📗 | o Be | examiner? 1 Yes 2 No Hospital: 1 Inpatien | t 2 ER/C | Outpatient | 3 🔲 DOA | Other ₄ | Nursing Home 5 | Resid | dence 6 🗸 Other | : Scene |
| o # | After this funeral dire | | 27. Manner of Death 1 X Natural 5 Death (Month, Day, Yei | / 28b. ar) | Time of Inj | | ry at Work? | ı | e how ir | njury occurred | |
| ion ttendi | - 4- | 읉 | 2 Accident Investigation | | | | Yes 2 | | | | |
| Division of Vital Records, rail or Attending Physician: The law requires after death. | filled in by | Certification: | 3 Suicide 6 Could not be determined (Specify) | ry - At home, f | farm, street, | factory, office b | ouilding, etc | 28f. Location or Town | | and Number or Rui | ral Route Number, City |
| Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific | unera | | 4 Homicide 29a. Certifier 1 Certifier Physician: To the best of my | knowledge d | eath occurre | ed at the time de | ate and place | ce, and due to the ca | use(s) a | and manner as state | ed. |
| the B | To the Fun completely | Medical | one) 2 Medical Examiner: On the basis of exam | ination and/or | investigation | on, in my opinior | , death occ | surred at the time, da | te and p | lace, and due to the | e cause(s) |
| F William | 7 S | Ž | and manner stated. 29b. Signature and title of certifier | 11-1-8 | 22 | 29c. Licens | e number | | 29d | . Date signed (Mor | nth, Day, Year) |
| | | | Thetor Walter Weed | 7 | 0 | O.C. | M.E. | | Fe | bruary 9, 2012 | |
| | | | 30. Name and address of person who completed cause of de | ath (Item 23a) | | | | | | | |
| | | | Victor Weedn MD JD Assistant Medical | | 900 W. | Baltimore S | treet, Ba | altimore, MD 21 | 223 | | |
| В | St eaist | | 31. Date filed (Month, Day, Year) 32. Registrar | s Signature | lon | Kel | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 31^{pay} Amelia Carol Sanders 2012 January 9:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Manchester 1920 East Deep Run Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year, 220-26-0161 79 Yrs. **Director** 1 □ M 2 🛚 F Maryland Feb. 14, 1932 "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Manchester Maryland Carroll County 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21102 United States 72 hours after death with 1920 East Deep Run Road 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: white If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) registered nurse nursing 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna M. Grimes ၉ Herbert N. Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8399 Williams Drive Frederick, Maryland 21704 Rebecca Bell / niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation 20a. Method of Disposition 20c. Location - City or Town, State Feb. 1, 1 Burial 2 X Cremation 3 Removal from State Hampstead, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Eline Funeral Home Signature of Funeral Service Licens 22. Name and Address of Facility M01072 Hampstead, Maryland 21074 934 South Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin , such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on _ach line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially flat conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the at d be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 A No After this certificate 1 Yes 2 No сотрletely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural
2 Accident
3 Suicide work? 5 Pending 2 🗌 No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Edward Swinderman January 24, 2012 6:30 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Jan 2, 1920 Hours Mary land 215-26-1899 92 Director Usual Residence of Decedent la or 28a-f show be notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Westminster Maryland Carroll 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 250 St. Luke Circle, suite 610 "natural", or items 23a 21158 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give W Black White etc ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: white Completed 3 Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Church Organist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Ray Anders Mary Agnes Swinderman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ted Dix, friend 837 Ewing Drive, Westminster, MD 21158 Baltimore, 20a. Method of Disposition 20b Place of Disposition (Name of Stemeted, ORMstory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/27/2012 Westminster, MD Catholic Cemetery 21. Si ature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Interval Between Onset and Death sho Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performe Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death Certificate: 28a. Date of injury 28b. Time of To the mospinal within 24 hours after death.

To the Funeral Director: After the funer will also the funer funer that the funer will also the funer fu 28c. Injury at 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 13 Cer lifying Nurse Prantioner: To the best of my knowledge, death cerum diat the time date and plane, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinento Center 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Malos m DR.

Westminster MD 21157

Name and address of person who completed cause of death (Item 23a) (Type, Print)

N + PANSURIYA 3 H9 Malos)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20. 2012 07:19A M William Swanner January Robert Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** ^{Year}1945 Month, Bay May 30 Days 1 XM 2 □ F Director 219-42-9287 66 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 TNo Carroll Westminster 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 1225 Nottingham Road 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 0 1 Never Married 2 X Married 1 Yes 2 No þ Maryland 21215-0036 Hygiene. other than "natural", 1 ☐ Yes 2 🙀 No Specify White 3 Widowed 4 Divorced Completed Year or Dates. 1969-75 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Food Sales should be filed with and Mental Hygien is marked other th Wholesale Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Earl Swanner Frances Davis permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bonita M. Swanner (Wife) 1225 Nottingham Rd., Westminster, MD 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation: 1/21/2012 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Signature of Funeral Service Licenses PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) 4 | Pregnant 1 Yes 2 L 9 Unknown ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy certificate To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: eral Director: After filled in by the funer Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

Center

St.

Westminster,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dimonto,

JAN24

Johanna U 31. Date filed (Month, Day, Year) M.D.

555

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ■Month 1512 Physician/ Alma Spurlock Januar Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Façility Name (if not institution, give street and number) Examiner Montyomer akoma Park Nashington Advantist HOSPITA 8. Date of Birth Month, Day, Birthplace (State or Foreign last birthday) 5. Social Security Number Funera! Hours aswell. N. lawling Director Usual Residence of Decedent 10d. Inside Çity Limits "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. Director Rainier 1
Yes 2 □ No Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 20712 USA. A618 2200 venue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black. 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Principle Elem. School Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ Utelen Creorge Carlton Graves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4618 2210. Avenue Mount Roun in Mil. 20112 19a. Informant's Name/Relationship (Type, Print) Helen Graves / DaughtER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Comp Springs (hurch 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Comp Reidsrille, N. Corolina 14/2012 COTNEY 5 4 ☐ Donation 5 ☐ Other (Specify) FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Sprvice Licenses Washington De 2004 3931 Georgia Avenue Mr. CC 0218 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Atheroscleratic Physician/ Coronary artery disease or condition resulting in death) Medical Examiner pertonsion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner o (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗙 No Month Day Pregnant at time of death 1 Yes 2 signed by the and be detached for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pate has l performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FR/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier January 30, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Are Takoma Park Amber Marshall 7600 Carro

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND #25 per dr. 02/08 entiticate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year Theodore Sample 1:45 P M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Arcola Nursing Home Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) V Δ Social Security Number 7. Age (In yrs, last birthday) **Funeral** Days 1 XM 2 🗆 F Months Hours (Month, VA 225-32-9767 Director 04-01-1931 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Prince George's Suitland 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US 6008 Elmendorf Drive 20746 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married ģ 1 XYes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Financial Examiner Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mente Important: If item 27 is marked any injury or other traumatic events. ပ Daisy Sample John Sample 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6008 Elmendorf Drive, Suitland, MD 20746 Emily Sample /Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans matory or other place 02-01-2012 Cheltenham, Cheltenham ame and diress of Facility Pope Funeral Homes, P.A. 21. Signature of Fane al Service License 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line aptications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Aspiration of Gastric Contents disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Acute Upper Gastrointestinal Bleeding with Vomiting Security is conditional if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of burial-transit resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ctopic pregnancy for Hospital or Attending Physician: The law requires that the death of thours after death.

Funeral Director: After this certificate has been signed by the attentions. in the past 12 months? Month Day Year Other (specify) Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician; The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sit completed filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 TANO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practifier: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of D09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Barry N.

FEB 0 3 2012

3720 Farragut Ave, Kensington, MD 20895

M.D.

32. Registrar's

Rosenbaum,

12-00651 Denise Short

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | 1- For State | Certificate | | ontai riygione | Reg. No. 201 | 2 0456 |
|--|---|--|--|----------------------------|------------------------------|-------------------------------|
| Physician/ | Registrar 1. Decedent's Name (First, Middle,Last) | | | 2. Date of D | eeth | 3. Time of Death |
| Medical Examiner | Denise Hope Short | | _ | January | 23, 2012 | 2342 hrs |
| | 4a. Facility Name (if not institution, give street and | | 4b. City, Town, or Locati | on of Death | 4c. County of Deat | h |
| | Peninsula Regional Medical Cente | | Salisbury | -d040 To | Wicomico | dhalana (Ctata a- |
| Funeral | 5. Social Security Number 6. Sex | 7. Age (In yrs. last birthday) | | ours Min | Birth(MM/DD/YYYY) 9. Bi | gn |
| Director | 213-78-3199 1 M 2 🔀 | F 47 | Yrs. | July | 18, 1964 C | ountry) DE |
| any | Usual Residence of Decedent 10a, State 10b, County | 10c. City, Town or Lo | cation | | | 10d. Inside City Limits |
| E | | | | | | 1 Yes 2 X No |
| Aaryland 28a-f show 1 at once. | DE Sussex 10e. Street end Number | Delma | 10f. Zip Code | | 10g. Citizen of What Cou | untry? |
| the Maryland a or 28a-f sh tified at once | 37901 Marsha Street | | 19940 | | U.S.A. | |
| imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoo or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | 11. Marital Status 12. Was | | Was Decedent of Hispanic | | | rican Indian, Black, |
| er death with the street of th | 1 Never Married 2 X Married Arme | 77 | If Yes, specify Cuban, Mexi | can, Pueno Rican, etc.) | White, etc. | 1 * |
| ral", o | 3 Widowed 4 Divorced If Yes, Give or Dates: | Vilar | Yes 2 X No spec | | Specify: | white |
| hours Exam | 15. Decedent's Education (Specify only highest | during | dent's Usual Occupation (G g most of working life. DO N | | 16b. Kind of Business | rindustry |
| 5-0036 ed within 72 hour 18 yigien "natu other than "natu the Medical Exan Completed | Elementary/Secondary (0-12) Colleg | e (1-4 or 5+) | conductor | | transp | ortation |
| 1 with giene | 17. Father's Name (First, Middle, Last) | | | ther's Name (First, Middle | | |
| 215 be file ontal Hy rked o | John Carpenter | | | Nevada Jar | | |
| 213 ould b d Men d Men d Men fic eve | 19a. Informant's Name/Relationship (Type, Print) | i i | iling Address (Street and | | | |
| MD d 2 sh lth and lth | James Short (Husba | | 01 Marsha St | | ar, DE 1994 | |
| re, f Heal f fite frite | 20a. Method of Disposition 1 Burial 2 XX Cremation 3 Remove | ol from State crematory of | position (Name of cemetery r other place) | | | |
| Page nent o | 4 Donation 5 Other Specify: | Cremator | y of Delmarva | | 012 Delmar, | Delaware |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at none. To Be Completed by Funeral Director | 21 Signature of Funeral Service Licensee | 4.1 | 2. Name and Address of Fa Short Fune: | ral Home | | |
| | 23a. Part I. Enter the disease, or complications th | at caused the death. Do not ent | 13 East Gro | ove Street I | | 19940 Approximate Interval |
| Physician Vegical | failure. List only one cause on each line. | | | | | Between Onset and Death |
| Examiner | | osis, left circumflex coro | mary artery | | | |
| | Sequentially list conditions, b | | | | | |
| ner | if any, leading to immediate Due to (or caus). Enter Underwing Couse | as a consequence of): | | | | |
| ted 1 Insit Examiner | (Disease or injury that initiated events resulting in death) Last | as a consequence of): | | | | |
| Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transic Completed by Physician/Medical E. | d | | | | | |
| 60, ate be execui hysician and e burial - tra | UNPENDED AMENDI | ED | | | | |
| 760, icate be physic the buri | DOL 144 In reduct response tip the | es, outcome of pregnancy ve birth 2 | Fetal death 3 Ec | topic pregnancy | 23d. Date of delive Month | ry Day Year |
| certif | past 12 months? | ve birth 2 | Other (Specify) | topio pi og.i.a.i.o, | 7 | |
|). Box 687 the death certific by the attending p ched for use as th Physician/ | | nknown | | | | |
| P.O. that the greed by the detache by the by the detache by the by the by P. I. | Part ii. Other significant conditions contribution | ng to death but not resulting in t | he underlying cause given i | | d tobacco use contribute t | |
| S, P nires ti d be d bed b | | | | 24a. W | | autopsy findings available |
| ords w requisited shoul | | | | au | | completion of cause of |
| Records, The law requires ficate has been signate, page 2 should be Completed | | | | | es 2 No 1 V | |
| Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be executed its after death. 31 Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit ertification: To Be Completed by Physician/Medical Exertification: To Be Completed by Physician/Medical Exertification: | 25. Was case referred to medical examiner? | | TO the sec | eath (Check only one) | | |
| Physic at this at direction | 1 Yes 2 No | Inpatient 2 ER/Outpat Date of Injury 28b. Time | HOIR O BOIL | | Residence 6 Oth | er: |
| ding J | 27. Manner of Death 1 Natural 5 Pending | Ionth, Day, Year) | 1 Yes 2 | | , | |
| Sion Attentant destruction by the cation ication | 2 Accident Investigation 28e. | Place of Injury - At home, farm, | street, factory, office buildin | | n (Street and Number or F | Rural Route Number, City |
| Division o spital or Attending hours after death. neral Director: After filled in by the fune Certification: | 3 Suicide 6 Could not be determined (Spe | | | or Tow | n, State) | |
| Di Hospital 24 hours : Funcral etely filled | 29a. Certifier 1 Certifying Physician: To the | best of my knowledge, death o | ccurred at the time, date an | d place, and due to the c | ause(s) and manner as st | ated. |
| Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should Medical Certification: To Be Complete | one) 2 Medical Examiner: On the ba | asis of examination and/or inves ner stated. | | | | |
| H 3 H 3 | 29b. Signature and title of certifier | | 29c. License nun | | 29d. Date signed (M | |
| | ane 2 | | O.C.M.E. | | January 24, 20 | 14 |
|) TE | 30. Name and address of person who completed Ana Rubio MD. Assistant Medic | cause of death (Item 23a) cal Examiner 900 W. E | Baltimore Street, Balt | imore, MD 21223 | | |
| State | 31. Date filed (Month, Pay, Year) 2012 | Projetrar's Signature | barker | | | |
| Registrar | ONITA LOIS | many po. 19 | AMAL DOLL | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Herbert Stevens 4:32 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death salislown Hospice at the Wicomico Coastal If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Min. Hours 218-12-1127 **Director** 90 1 **X** M 2 □ F 12/27/1921 Maryland Usual Residence of Dece or 28a-f shov the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MD Worcester Snow Hill 1 🗌 Yes 2 🔀 No 10f. Zip Code 10a. Citizen of What Country? by Funeral with or items 23a 6139 Disharoon Road 21863 USA filed within 72 hours after death all Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 21215-0036 White 1 ☐ Yes 2 X No Specify. "natural", 3 Divorced 4 Divorced Completed Year or Dates. 1944-46 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Appliances and Mental Hygien Serviceman Be Baltimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked or any injury or other traumatic ew ည Helen Boise Marshall Arthur Leslie Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6139 Disharoon Rd, Snow Hill, MD 21863 Betty Grace Stevens/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 02/05/2012 Bates Cemetery Snow Hill, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Home 13 E Grove Street, Delmar, DE 19940 Part 1. Enter the disease, or comp shock, or hear failure. List only on ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician DAMBNTIA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury) Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28c. Injury at Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Gertifying Nurse Practitioner: To the best of my know 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S WA 132

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Monto

istrar's Signature

| | For State Registrar 1. Decedent's Nam | e (First Middle | | Marylan | | artment tificate | | | and N | /lental Hyg | eg. No. | 012 | 0155 |
|------------------------------|---|---------------------------------|--|--------------------------------------|-----------------------------------|-------------------------------|-----------------------------|----------------------------------|-----------------|---|-------------------------------|---------------------------------|--|
| cian/ dical | | Robert | ŕ | aylor | | 4b. City, To | own or l | continu | of Dooth | January | 23, | 2012 nty of Death | 0602 M |
| niner | Carrol] | L Hospic | e Dove Hou | ıse | | ₩ | estm | inst | er | | (| Carrol | |
| ral or | 5. Social Security N 212-30-1 Usual Residence | L069 | 5. Šex 7. / 1 2⊈ M 2 □ F | Age (In yrs. Ia | ast birthday) Yrs. | If Under 1 Months | Days | If Under Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day, Oct 11, | Year) | Count | lace (State or Foreign try) ryland |
| nneral Director | 10a. State | 10b. County Carr | coll | 10c. City | , Town or Loc West | cation minste | er | | | | | 1 | 0d. Insi d e City Limits 1 |
| Funeral Director | 10e. Street and Nur | | rcle Apt. | 127 | | 10f. Zip 0 | Code 211 | 58 | | | | of What Coun | try? |
| d by Fu | 11. Marital Status 1 Never Marr 3 Widowed | ied 2 🖾 Marrie | 12. Was Deceder | nt Ever in U.S s? X No | If | Vas Deceder Yes, specif | y Cuban | , Mexicar | gin? (Spe | ecify Yes or No- Rican, etc.) | | ace - America lack, White, e | |
| once. To Be Completed | (Spe | | | | 16a. Deced (Give k life. DC | aind of work NOT use r | done du | | t of work | ing | Balti | Business/Ind more Cools | , |
| To Be (| 17. Father's Name (| First, Middle, La | st) | | _ reac. | 1161 | | | | e (First, Middle, 1 Zelner | | | |
| | | ane Tayl | or/ Wife | | 19b. Mailin | , | | | | t 127 V | | , State, Zip C nster, | |
| | | | Removal from Sta | te C6 | lace of Disposemetery, crem | remat | ier place | Inc | 1/ | Date 24/2012 | Hamp | | Maryland |
| | 21. Signature of Fu | neral Service Lic | consee | | | | | | | ts Fune: Westr | | | hapel, PA 21157 |
| n/ al | | rt failure. List on (Final | omplications that causely one cause on each I | ine. | . | r the mode | of dying | , such as | cardiac (| or respiratory arre | est, | | Approximate Interval Between Onset and Death |
| er | Sequentially list co if any, leading to in cause. Enter Unde | onditions, nme d iate | b. Polare Due to (or a | is a consequi is a consequ | Bapu | va-ce | سم | m | een | enu | | | 4 Maye |
| cal Examiner | cause. Enter Unde Cause (Disease or that initiated event resulting in death) | injury s | | s a conseque | Aromi ence of): | nocy | tory | فس | e | | | | 4Dys |
| Completed by Physician/Medic | IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown | months? | 23c. If yes, outcon 1 | h 2 ☐ Fetal t at time of d | death 3 | Ectopic pro Other (spe | | , | | | | Date of delive | ery Day Year |
| d by Pr | | | is contributing to death | | _ | nderlying ca | | ما | l. | 23e. Did to | | | e cause of death? |
| Complete | | 0 | | | | | | 7 | <u> </u> | 24a. Was a autop: perfor | med? | | osy findings available mpletion of cause of |
| To Be | 25. Was case referrence examiner? 1 Yes 2 | ed to medical | Hospital: | atient 2 🗆 | ER/Outpatien | t 3 DOA | Othor | | | k only one) ome 5 Reside | ence 6 | ther (Specify) | Dervette |
| Certificate: | 27. Manner of Death | 5 Pending Investiga | ation | | 28b. Time of injury | 280 M | c. Injury work? 1 🔲 ነ | | | 28d. Describe ho | w injury occ | urred | |
| | 3 U Suicide 4 U Homicide | 6 ∐ Could ne determin | 28e. Place of I | njury - At hor etc. (Specify) | | et, factory, | office | | | 28f. Location (St City or Town | | nber or Rural | Route Number, |
| Medical | (Check 2 only one) 3 | Medical Ex | Physician: To the best aminer: On the basis of Nurse Practition : To | examination | and/or invest | igation, in my death occur | y opinior red at th | , d eath oo e time, da | ccurred a | t the time, date ar ace, and due to th | d place, and e cause(s) an | due to the cau d manner as s | ise(s) and manner state tated. |
| | 29b. Signature and | title of Zertifler | 4 | | | | License | CLLC CLLC | 4 | | 0 | ned (Month, E Q 니七 | 12012 20157 |
| | 30. Name and addr | ess of person w | ho completed cause of | death (Item | 23a) (Type, P | | | | • | | | MIIO. | 2115 |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ January 29, 2012 Eloise Hise Taylor 4:55 рм **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Wicomico 6431 Crockett Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 235-56-1805 75 **Director** 1 M 2 X F 06/04/1936 West Virginia or 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Salisbury Maryland Wicomico 10e. Street and Number 10g. Citizen of What Country? Funeral 21801 6431 Crockett Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 M Married 1 Yes If Yes, Give 72 hours after 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 🗌 Widowed 4 🗆 Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Telephone Service Representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James W. Hise Wilda Hamner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6431 Crockett Lane, Salisbury, MD 21801 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau John A. Taylor/spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Rockawalkin U.M.
Church Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/3/2012 Hebron, MD Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Dompson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arthriti disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Day Year ed by the a 1 Yes 2 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Nonknown Completed neuropathy 24b. Were autopsy findings available prior to completion of cause of 24a. Was an peripheral has autopsy performed' death? certificate I 1 Yes 2 No 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA After this To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? ___1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Hospital or Attending Natural injury 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) erson who completed ca use of death (Item 23a) (Type, Print) Jame and addres

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** 10:30 John 2012 January /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bavview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) Sept. 29, 1921 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 90 214-14-4609 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show "natural", or Items 23a or 28a-f sho Punta Gorda 1 Yes 2 No FLCharlotte Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 33955 2461 Dolphin Cove Drive death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces?

1 X Yes 2 No WWII

If Yes, Give Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: <u>م</u> 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Is marked other than Pages 1 and 2 should be filed with nent of Health and Mental Hygiene. Administrative Law Federal Judge 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosemary Walker Ralph Underwood ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 108 Bay Shore Road, Hyannis, MA 02601 permit. Pages 1 and 2: Department of Health an Important: If item 27 Is any Injury or other trau Jacqueline Underwood/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olive Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition January 2012 25, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, MD 4 Donation 5 Other (Specify) Barranco & Sons, P.A. 495 Ritchie Hwy, 21. Signature of Funeral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1 Criter by disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart affore. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final weeks **Physician** disease or condition /Medical resulting in death) Due to (or s a consequence of) **Examiner** theumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unserge of the second sec Examine Due to (or as a consequence of): that initiated events resulting in death) Last the burial-trar and Due to (or as a consequence of): attending physician Box 68760. Physician/Medical certificate be use as IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy for Month in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No detached P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, ate has been signe page 2 should be 1 Tyes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate has performe 2 2 □ No Yes Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☑ No Hospital 1 🗹 Inpatient 2 ER/Outpatient 3 DOA ၉ Hospital or Attending Phys 24 hours after death. Funeral Director: After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Injury 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the I within 2: To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 Kornb State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Her. Wa oris <u>February</u> 8. 429 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Carroll Westminster 5. Social Security Number 220-30-1752 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year, Country) 79 Director 932 Maryland August 6 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location **Westminster** 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Carroll 1 Yes 2X No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21158 **USA** 205 St. Mark Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 X Never Married 2 ☐ Married Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other traumatic event, the Me life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Schools Educator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Helen Amelia Hedrick Ervin Howard Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 E. Main St., Westminster, MD 21157 Amber Dahlgreen Curtis/Attorney Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any Injury or Lakeview Mem. Gardens02/14/2012 Eldersburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Printers Aftenerally Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial ₽hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events iner Due to (or as a consequence of) Exami law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N To the Hospital or Attending Physician; The 2 - No After this certificate Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Division of Vital 8 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at Natural 5 Pending work 1 🗌 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check 3 🗆 Certifying Nurse-Rractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State

Registrar

31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print)

32. Reg

20/2

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person

U

6

Date filed (Month, Day,

Ster MD 21157

who completed cause of death (Item 23a) (Type, Print)

Green

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Phyllis Ray Wilson January 27, 2012 9:00 а м Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Sykesville Carroll 452 Klee Mill Road Social Security Number Year If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) 218-40-7660 68 **Director** 1 M 2 X F Virginia Jan 5, 1944 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Sykesville Carroll Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA Funeral 452 Klee Mill Road 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: white 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Louise Null Forrest Ray Cook 19a. Manarcan Ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or any 452 Klee Mill Road, Sykesville, MD 21784 Wayne Wilson, husband 20b. Place of Disposition (Name of Street, sematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Winfield, MD 01/30/2012 Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) Myers-Durboraw Funeral Home 22. Name and Address of Facility Signature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 23a. Part)1. Enter the disease, or complications that caused the sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Physician/ disease or condition Medical resulting in death) **Examiner** quantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) executed the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Day Year Pregnant at time of death signed by the ar 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform death? 2 No 1 🗌 Yes Yes funeral director, Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No မြ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural iniury work? 1 🔲 Yes 5 Pending s after death. 2 🗌 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature anuare

DHMH 17 Rev 06-2011

Registrar

State

S NAL

WASHINGTON

ROAD,

SUITE 200

WESTMINITER, MD

21157

dress of person who coro leted cause of death (Item 23a (Type, Print)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Welden Beatrice Pauline 4:37 $\mathbf{P}^{\,\mathsf{M}}$ JANUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min 234-36-2136 **Director** 1 □ M 2 F 89 6/9/1922 WV Usual Residence of Deceder or 28a-f shov nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shoortant: If item 27 is marked other than "natural", or items 52a or 28a-f shoinly or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Cockeysville MD 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14830 Falls Road 21030 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Pleasant Viers Ethel Nolen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella Gail Thompson, daughter 14830 Falls Road, Cockeysville, MD 21030 permit. Page 1 and 2 Department of Health Important; If item 2: any injury or other tonce, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Black Rock Cemetery 1/28/2012 Butler, MD Eline Funeral Home 21. Signature of Funeral Service Licenses M00741 22. Name and Address of Facility Naule 934 S. Main St., Hampstead, MD 21074 Lemmes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ADRTIC DISSECTING disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate Examiner Due to (or as a nonsequence of) if any leading to immedicause. Enter Underlying the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 24 hours after death.

Funeral Director. After this certificate has the funeral director, page 2 s performed 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\triangle \text{ Other (Specify)} \) 2 No ၉ 1 Inpatient ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one title of certifier 29b. Signat 29c. License numbe 29d. Date signed (Month, Day, Year) 00255

State

NAIO

Registrar

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type,

Year!

JAN26

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bery1 Patricia Wallace January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sun Valley at Ridge Overlook Westminster Carrol1 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country). England 8. Date of Birth **Funeral** (Month, Day, Y Days 1 □ M 2 👿 F Hours Months Min. Yrs 91 Director Nov. 449-35-7049 1920 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 VNo MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3816 Ridge Road 21157 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: 3 X Widowed 4 Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Reginald Whitehead Edith Frances Heath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7452 Brandenburg Cir Sykesville, Md 21784 Mrs. Deborah Dupuy (Daughter) or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 X Burial 2 Cremation 3 X Removal from State Toledo Bend Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2012 Newton County, TX 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Signature of Funeral Service Licenses Sykesville, 195 Box MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Atherosc Cardioviscular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available certificate has prior to completion of cause of death?

1 Yes 2 No autopsy Yes within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 \square Nursing Home 5 \square Residence 6 \not Other (Specify) A(\vdash \(\text{Unn}\) 2 × No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Bégistrar's Signature

1AHMOUD

2012

31. Date filed (Month, Day, Year)

JAN24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Wilson Robert Alexander 1338 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SAL15641 L/ICHMIOD Medical YENIASULA REGIONAL If Under 1 Year If Under 24 Hr . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 218-40-5712 Director 1 🕱 M 2 🗆 F 69 09/05/1942 Maryland 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Director be notified 1 X Yes 2 No Maryland Wicomico Salisbur 10f. Zin Code ō 10e. Street and Number 10g. Citizen of What Country? Funeral "natural", or items 23a 9097 Gateway 21801 USA Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

I X Yes 2 □ No
If Yes, Give
Year or Dates. Army Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify: Black Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) than, life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the Driver Taxi Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard H. Wilson Etha Mae Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Bonnie Thompson/Daughter 8390 Pittsville Rd., Pittsville, MD 21849 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Eastern Shore of MD 4 ☐ Donation 5 ☐ Other (Specify) 2/2/2012 Hurlock, MD Cemeter Signature of Funeral Service Licensee Stewart Funeral Home by Holloway and Downey, P.A. KallA CFSF 821 West Rd., Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a col requires that the death certificate be executed and I-tran Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a detached i g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed 1 Yes 2 No Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospita n 24 hours after deau.. he **Funeral Director:** After this ce noletely filled in by the funeral dire 2 000 Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check To, the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practition only one title of certifier 29d. Date signed (Month, Day, Year, 29b. Signature ar

State Registrar 10 mas

2 2012

30. Name and address of person who com-

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eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February 02 Year 2012 Physician/ Philip WOMA 0425 AM Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death
Balkimo 4b. City. Town, or Location of Death **Examiner** Randallstown Northwest 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 5. Social Security Number 9 Birthplace (State or Foreign **Funeral** Hours Min. M 2 D F Months New York Director 83 083-28-1662 Usual Residence of Decedent 28a-f show 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Ellicott City MD Howard or. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a United States 2205 Kaitlins Court 21043 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Chinese Completed 3 Widowed 4 Divorced M dical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Food Technology Chemist other traumatic event, Be Department of Health and Montal H Important. If item 27 is marked or any injury or other to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fong Shee Ate Wong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2205 Kaitlins Court Ellicott City, Maryland 21043 Bing Wong/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 2/6/2012 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityHarry H. Witzke's Family FH, Inc 21. Signature of Funeral Service License 4112 Old Columbia Pike Ellicott City, MD 21043 uanita 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ dystythnia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): hyperkension and -transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 4 ☐ Pregnam 9 ☐ Unknown the 1 ☐ Yes 2 ☐ Unknown is been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q hyperlipidenia Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Meningions Jas autopsy certificate ha perform death? 2 No 2 7 Yes 25. Was case referred to medical examiner? Vital Be 26. Place of Death (Check only one) 2 % No Other: ည 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred o the Hospital or Attending P Ithin 24 hours after death. Ithe Funeral Director: After to expleted filled in by the funeral Certificate: 1 X Natural 5 Pending work 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) d \$\$68783 2012 02/02/ MD 5401 Old Court Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jo

Registrar DHMH 17 Rev 7/2009

State

Michael

31. Date filed (Month Per

barks

32. Registrar's Signature

Randallstown, Maryland 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 10:41PM Mary Carol Watson Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Hospice at Salisbury oastal omic If Under 1 Year If Under Security Number 7. Age (In yrs. last birthday) 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) Director 221-48-7577 49 1 □ M 2 🕱 F Oct 12, 1962 DE Usual Residence of Decedent or 28a-f show notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be n Funeral 322 E. Vine Street 21802 USA items 2 death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 Never Married 2 Married // I & r り VV マナン こい altimore Maryland 21215-0036 🗌 Yes 2 😾 No African-If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced Completed American is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. 12 University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be file Health and Mental 2 Preston Watson Mary Everett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Priscilla Hitch/daughter 30623 Pine Knoll Drive, Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Mem Park 2/4/2012 Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) Signature of Funeral Service Licensee Approximate nterval Between Onset and Death Immediate Cause (Final Physicsen/ ACOLIRED PMMUNODRFFIGENY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ned 1 9 Unknown be detack signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2/10 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed Yes 2 death? 1 Yes director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes Other: HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 🗌 No within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month,

State

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31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrat's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ SHARON LEE WHITE 9:50 M 2012 Medical 4a. Facility Name (if not institution aive street and number 4b. City Town, or Location of Death 4c. County of Death Examiner Wicemic Funder 1 Year | If Under 24 Hrs tospice oasta 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Hours Min (Month, Day, Year) Country) 215-62-1268 58 **Director** 1 🗆 M 2 🕱 F 03/23/1953 Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits at Director must be notified MD Wicomico 1 Yes 2 X No 28a-f Salisbury 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 0 Funeral **23**a 200 Atlantic Ave 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. o δ 1 Never Married 2 Married 1 Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Beverage Distributor Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Sharon Floyd Miller Veronica Nemith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 Weldon Thomas White/spouse 200 Atlantic Ave, Salisbury, MD 21804 Department of Healt Important: If item 2 any injury or other injury or other Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Springhill Mem Gardens 01/27/2012 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Short Funeral Home 13 E Grove St, Delmar, DE 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ MRTASTA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an , page 2 s autopsy perform has death? Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospita Other: 405P11Z 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of nours after death.

neral Director: After the filled in by the funera Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

26

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1300 Registrar's Signatur

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| | | 1 _ State | Maryland | | rtment of F | | nd Mental I | | 201 | 2 01.57 | | |
|---|---------------------------|---|-----------------------------------|--------------------------------|---|----------------------|--|---|---|---|--|--|
| | | 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) | | | | | | Reg. No | o. 201 | 3. Time of Death | | |
| Physicia | | Malinda E. Wigfall | | | | | | | y Year 2012 | 6:57 A ^M | | |
| /Medic Examin | | 4a. Facility Name (If not institution, give street and num | aber) | | 4b. City, Town, or | Location of | Jan Death | | c. County of Death | 1 | | |
| | | 10795 Riley Roberts Road | | | Dames | | | | Somerse | | | |
| Funeral | | 1 TH OFF | 7. Age (In yrs. la 84 | ast birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hours | Hrs. 8. Date of Monte | Birth Day 1922 | 9. Birth | place (State or Foreign intry) | | |
| Director | | 218–24–3970 LSual Residence of Decedent | 01 | 710. | | | 1000 | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | N | D | | |
| yland | | 10a. State 10b. County | 10c. Cify | y, Town or Lo | cation | | | | | 10d. Inside City Limits | | |
| e Mar Sa-f sl | ctol | MD Somerset | Da | ames Qu | | | | | | 1 X Yes 2 □ No | | |
| vith th | Dire | 10c. Street and Number | 1 | | 10f. Zip Code | 11 | | 10g. C | itizen of What Cou USA | ıntry? | | |
| eath v | eral | 10795 Riley Roberts Road | dent Ever in U.S | S 13 V | 2182 Vas Decedent of H | | in? (Specify Yes o | · No- | 14. Race - Amer | ican Indian. | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and once. | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Molowed 4 □ Divorced 12. Was Decerations of the properties of t | ces? 2 □X No e | l t | Yes, specify Cuba | Specify: | Puerto Rican, etc. | | Black, White | | | |
| 72 hc | Completed | 15. Decedent's Education (Specify only highest grade completed) | | (Give | lent's Usual Occup | durina most c | of working | 16b. l | Kind of Business/I | ndustry | | |
| within ene. than ' | du | Elementary/Secondary (0-12) College (1- | 4or 5+) | | OO NOT use retired Oomestic/ | | ~~ | | Vario | 110 | | |
| filed v Hygid other | | 17. Father's Name (First, Middle, Last) | | | onestic/ | | s Name (First, Mic | ldle, Maide | | us | | |
| fental fental rked c | To Be | Raymond Bivens | | | | Mary | F. Whit | .e | | | | |
| and N | | 19a. Informant's Name/Relationship (Type. Print) | | 19b. Mailin | g Address (Street | and Number | or Rural Route No | ımber, City | or Town, State, Z | ip Code) | | |
| and | | Claudia Wheatley/daughte | | | Linden C | | ······································ | | | | | |
| ges 1 It of H If iter or oth | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S | state 20b. P | lace of Dispo emetery, cren | sition (Name of natory or other plac | i i | Date | | Location - City or I | | | |
| it. Pa urtmer rrtant: njury | | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee | Mac | | . Name and Addre | | 1/21/12 | Da | mes Quar | ter, MD | | |
| Depa Impo any l | | Talàna Duntor | I |] | ewis N. 1618 West | Watsor | n Funeral | Home | PA 21801 | | | |
| | | 23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea | used the death | | | | | | 21001 | Approximate Interval Between | | |
| Physician | | Immediate Cause (Final disease or condition Uterine Cancer 2 year | | | | | | | | | | |
| /Medical Examiner | | resulting in deeth) | or as a consequ | uence of): | | | | | | | | |
| Examine | <u>.</u> | Sequentially list conditions, b. | or as a consequ | tonce of: | | | | | | | | |
| nsit | Examiner | cause. Enter Underlying Cause (Disease or injury | derice oi). | | | | | | | | | |
| execunate and lal-tra | Exa | that initiated events | uence of): | | | | | | | | | |
| icate be executed physician and the burial-transit | dical | d | | | | | | | | | | |
| rtifica ng ph | Med | IF FEMALE: | 2.00 | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certifications after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | irth 2 Fetal ant at time of d | Ideath 3□ | Ectopic pregnand Other (specify) _ | ey . | | | 23d. Date of deli Month | very Day Year | | |
| s that gned b | Completed by Ph | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | tribute to the cause of death? | | |
| equire en si | | | | | | | 1 | ☐ Yes | 2√∑No 3□ Pr | obably 4 Unknown | | |
| law ra | | | | | | | <u> —</u> І а | Vas an lutopsy | prior to c | topsy findings available completion of cause of | | |
| : The cate h | | | | | | | 1 🗆 Y | erformed? es 2 N | | 2 🗆 No | | |
| ilcian certifi ector | Be | 25. Was case referred to medical examiner? Hospital: | | | t 3 DOA Oth | OF: | of Death (Check o | | | | | |
| Phys r this ral dii | 음 | 27. Manner of Death 28a. Date of | npatient 2 of Injury | 28b. Time of | IL 3 LI DOA | 4 🗀 Nui: | sing Home 5 28d. Descr | | 6 ☐ Other (Specury occurred | cify) | | |
| nding th. :: Afte e fune | tior | 1 □ Natural 5 □ Pending (Mont 2 □ Accident investigation | h, Day, Year) | Injury | | ḱ? Yes 2∐N | | , | • | | | |
| r Atter er dea rector | tific | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or 7 | | | | | | on (Street a | (Street and Number or Rural Route Number, own, State) | | | |
| oital or urs aft eral DI | Medical Certification: To | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | | 29a. Certifier 1 Certifying Physician: To the beast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| To the Congression | M | | | | | | | | | | | |
| | | C Sagra- My D25219 1-25-1 | | | | | | | | | | |
| 5°C | | 30. Name and address of person who empleted caus Dr. Charles Stegman, 304 | 134 M+ | Vernor | n Dd Dr | incess | z Anno M | מו מ | 53 | | | |
| Sta | te | 31. Date filed (Month, Day, Year) 2012 32/A 26 2012 | egistrar's Signa | ture | · IM., PI | 1110033 | Aute, I | U 210 | | | | |
| Registr | ar | JAN 20 2012 Da | egistrar's Signa | B. 100 | ake | | | | | | | |
| HMH 17 Rev 1/20 | 001 | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 04580 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Waddell George L. 7-2012 11:39 LM Medical Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Salisbur Icom 10 ice at th If Under Birthplace (State or Foreign Country) If Under 8. Date of Birth Age (In vrs. last birthday) **Funeral** Months (Month, Day, Year) 223-38-5553 **Director** 1**X** M 2 □ F 79 12/15/1932 Virginia Usual Residence of Deced 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 1 Yes 2X No Maryland Wicomico Salisbury ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? . 23a i Funeral 600 Belvadere Terrace 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 X Yes 2 No If Yes, Give Army Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify. 3 Divorced 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Sales Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Lewis Waddell Elsie Whittaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Waddell/spouse 600 Belvadere Terrace, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State ٥ 1 X Burial 2 Cremation 3 Removal from State Wicomico Memorial injury (2/1/2012 tion 5 Other (Specify Salisbury, MD 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 any 1. Enter the disease, or complications the used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Onset and Death rediate Cause (Final Physician/ TAGE isease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** HBIMRA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): sbeen signed by the attending physician should be detached for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes page 2 has death? 1 Yes 1 Tes Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes TOSPICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA ending,
enter death.

al Director: After the
tin by the fur 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 27. Manner of Death 28d. Describe how init. iniury Natural 5 Pending 2 No M 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined building, etc. (Specify) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of certifier 29d. Date signed (Month. Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) stringle 130 82. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Willette Helen Evans January 2012 Medical 30, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Fruitland Wicomico 807 West Main Street Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year) 221-26-1692 Director 1 M 2 X F 72 Yrs 01/14/1940 Delaware Usual Residence of Decedent show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? must be r Funeral 21826 807 W. Main St. USA items death v 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Examiner Black, White, etc. Z 1215-0036

Z 121 þ 1 Never Married 2 X Married White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Elbert Evans Sr. Harriet A. Lukens 19a. Informant's Name/Relationship (Type, Print)
Theodore Willette Jr/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 W. Main St., Fruitland, MD 21826 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Salisbury Crematory 1/31/2012 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Error Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-trans Due to (or as a consequence of) Physician/Medical certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f g 🗌 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performed No No 1 Yes Yes 2 **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of certifier 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year,

Registrar

SHOPE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ENSTERN

32. Registrar's Signature

VOHRA

JAN 31

OGE SH

31. Date filed (Month, Day, Year)

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DR

SALISBURY MD

3912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ol Day 31 Physician/ 8:29 AM Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Marylew Medical 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours Min (Month, Day, Year) 214-68-9047 **Director** 1 □ M 2 🗷 F 57 Mar 10-28-1954 pland or 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items on any injury or other traumatic 10d, Inside City Limits 10a. State 10b. County **Funeral Director** 1 Yes 2 No klaldurf Marzland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Trefoll 20601 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 ☒ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homem Domes 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1refu Durchsmi) Nichole 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other MARI 8-12 4 ☐ Donation 5 ☐ Other (Specify) Signature of Juneral Service Licensee Name and Address of Facility MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of): Examiner truct Sequentially list conditions, Examine Due to or as a sonse juence of cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No should be detached for Month Dav Pregnant at time of death 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate has page 2 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Manner of Death 28c. Injury at Certificate: 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Pas 554 01/311

State Registrar MO

FEB

Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

32. Red

22

WM 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Charles Joseph Zampino 2012 7:40 P.M Jan. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Tranquillity at Fredericktowne Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 193-16-9073 Director 1**XX**M 2 □ F Nov. 11,1922 PA 89 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location at 10a State 10b. County Director Examiner must be notified 1 Yes 2 XXIo Frederick Maryland Frederick 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code P 23a Funeral United States 6441 Jefferson Pike 21703 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in L 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1943-Black, White, etc ö 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxNo Specify 1946 Specify: White "natural", 3 KWidowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Clothing 12th Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Zampino Josephine Department of Health and Important: If item 27 is n. any injury or other traum: 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1303 Volunteer Dr., Brunswick, MD 21716 Philip C. Zampino Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Resthaven Mem. Gardens 1/21/2012 Frederick, MD ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility

Name and Address of Facility

PA

Numrier-Oueen

Funeral Home & Crematory, PA

Ninfield MD 21784 21. Signature of Funeral Service Licenses Burrier-Oueen Funeral Ho 1212 W. Old Liberty Road caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval 3 etween Onset and Teath 23a. Part 1. Enter the disease, or complications the shock or heart failure. List only one cause of Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin and -tran that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical requires that the death certificate be P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Dav Pregnant at time of death Yes 2 No the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 520-50 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 Tyes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8 12 My51610 Michael 30. Name and address of person who completed cause of death (Item 23a) (Type, Pri

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Registrar

31. Date filed (Month, Day,

Tolino MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND PIET IN 1987 1987, Per INF, G928, 6725 2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY TO 2012 8:30 CHANANG Ам ODILIA ACHA-MORFAW Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY 21900 HUNTMASTER DRIVE GAITHERSBURG If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 T F Days Hours Min. MAY 4 1963 48 CAMEROON Director 215-08-7738 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD MONTGOMERY GAITHERSBURG 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21900 HUNTMASTER DRIVE 20882 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 XNo Black White etc. ò 1 Never Married 2 XMarried Maryland 21215-0036 72 hours after Completed by 1 Yes 2 No Specify: BLACK If Yes Give "natural", 3 Divorced Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with of Health and Mental Hygien fitem 27 is marked other the 6 yrs PHARMACIST PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ STEVEN MORFAW ROSELINE MMANKENA Α. traumatic 19a. Informant's Name/Relationship (Type, Print) Ajongako John Talieh/Husband John TALIEH/HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21900 HUNTMASTER DRIVE GAITHERSBURG, MARYLAND 20882 Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place FAMILY PLOT 3/17/2012 FONTEM, CAMEROOM 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) BREAST CANCER Medical Due to (or as a consequence of) Examiner DIABETES Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Ves 2 No Pregnant at time of death 5 Other (specify) Month Day Year the q 🗌 Unknown g Unknown signed by t Part II. **Other** s**ignificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed' certificate 2 No Yes 21 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 🛛 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) this Director: After the in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d, Describe how injury occurred Certificate: work? 1 🔀 Natural 5 Pending death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after within 24 hours a To the Funeral I To the Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D39190 and FEBRUARY 14, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3418 OLANDWOOD COURT SUIT 111 OLNEY, MARYLAND 20832 JOSEPH REILLY M.D. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Martyle V. Auman February 2012 0325 A 14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours (Month, Day, Year) Director 266-26-9024 1 □ M 2 🗶 F 86 Oct 28, 1925 New York show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f MD 1 ☐ Yes 2X No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8100 Connecticut Avenue 20815 USA ural", or items? death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: White "natural" Completed 3 Widowed 4 N Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Federal Government nt of Health and Mental Hygi :: If item 27 is marked other or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Edmund Simon Frances Kley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra E. Auman/daughter 7035—A Haycock Road Falls Church, VA 22043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Department Important: If any injury or Final Journey Crematory 02/16/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Sing Home Cremation Service P.O. Box 784 -MO1251 Beverly L. Heckrotte, P.A Clarksville MD 21020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Dementia resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🄀 No Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6X Other (Specify) hospice Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🛄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ASHER ANGELA 02 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death The Arc of Central Chesapeake Region Hanover Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) **Director** 522-94-3989 1 🗆 M 2 🗶 F 42 Yrs. 1-23-1970 Usual Residence of Decedent Maryland or 28a-f show artment of Health and Mental Hygiene. ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1510 David Victoria Lane 21076 United States filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mentally Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important; if item 27 is marke any injury or other traumatic. Richard John Asher Linda Marie Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Asher Brown 855 Snow Valley Lane Odenton, Maryland 21113 in - Law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) W. Arundel Crematory 2-16-2012 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final BRAIN Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician Medical law requires that the death certificate be P,O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown ed by the a 9 Unknown rate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **2** Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? • Hospital or Attending Physician: The 124 hours after death. • Funeral Director: After this certificate h 1 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Assisted completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1. Natural 5 Pending WORK! 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOW LUKHE, MD., 445 DEFENSE HEWAY, ANNAPOUS, MD ou LUXHB, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ZO/Z 00/Z M John Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Western Muriland Health System 41/ega If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 218-64-9368 1 🖾 M 2 🗆 F 56 Director March 27, 195\$ Maryland 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No **Allegany** Cumberland MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21502 205 Mary St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status med Forces? 2 No 1972− Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white ed other than "natural", event, the Medical Exam 1974 3 Widowed 4 XDivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) laborer construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Edward Burns Patricia Lipscomb other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Ray - sister 205 Mary St; Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 other Specify) Date cemetery, crematory or other place, Live of Funeral Serv 22. Name and Address of Facility State Anatomy Board 21201 655 W. Baltimore St; Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ hronic Obstructive disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for de a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Month signed by the a 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Q Q (iYC Division of Vital Records, MOSIS 1) Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s has Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Spe} \) 2 No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier

State Registrar

31. Date filed (Month, Day, Year) **FEB 17**

(Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1050 Industrial BIVA Cumberland, MD 2,502 Cindy Statter industrial Registrar's Sign

Medical Examiner: To the bast of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1312 Physician/ Month 02 201 Robin Lynn Broy Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Regional Medical mberlana Hiegan 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year, 215-86-3854 46 **Director** 1 □ M 2 🛣 Aug 21, 1965 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at death with the Maryland 10a, State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 💥 No Cumberland Allegany MT 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA Funeral 21502 322 Bedford St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after white If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 X Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) McDonalds 0 fast food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Shirley Rae Thompson David Clinton Widener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 322 Bedford St; Cumberland, MD 21502 Paul R. Goetz - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) . Signatur of Joneral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Due to (or as a consequence of): Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buris Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month 5 Other (specify) Pregnant at time of death P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> be Hypertension, Diabetes Division of Vital Records, 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed Yes 2 has To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examine . 1 Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No 4 hours after death. uneral Director: After ely filled in by the fur Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, in 24 hours the Funeral Directory filled in by 4 Homicide determined City or Town, State) Medical Çertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature

Paul

Snow,

FEB 17

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

124

W

Do9157

3rd St Cumberland MD 21502-4532

Feb 13 2012

amend #23a Per PHY G934 12/21/2012 JH
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #30 Per DyR G924 2/17/2012 JH
State of Maryland / Department of Health and Mental Hygiene
amend #5, per fh, 934 12-18-12 sm The partment of Health and Mental Hygiene ft, 934 12-18-12 sm Certificate of Death Reg. No. For State Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2012 Month Louis Michael Borum Feb. 6 10:30P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Health & Rehab. Ctr. Bethesda Montgomery 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1X M 2 □ F Hours Min Months 81 **Director** Mississippi Usual Residence of Decedent 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director MID Montgomery Chevy Chase 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 4701 Willard Avenue 20815 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 🔀 Yes 2 🗆 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Military Retired Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Booker T. Borum Valaria McNary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20815 4701 Willard Avenue #1627; Chevy Chase, MD. 19a. Informant's Name/Relationship (Type, Print) Towona Scott-Borum/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Md. Veteran Cem. 1 Burial 2 Cremation 3 Removal from State 2/16/2012 Cheltenham, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 20748 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. **Coronary Artery Disease** Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter organizing Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed the attending physician and the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Yea Pregnant at time of death 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 Yes 2 Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♥No 24a. Was an this certificate has autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 PNursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -s, uns 90057124 17112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lara Grace Villaneuva 9901 Medical Center Rockville, MD 20850 31. Date filed (Month State Registrar

12-00731 Scott Berman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| Scott Berman | | For State | ate of Mary | | artment of rtificate of | | and | Menta | al Hyg | | eg. No. | 201 | 2 | 04590 |
|--|---|---|---|-------------------------------------|----------------------------|-----------------------------|-----------|--|--|---------------------------------|---------------|--------------------------|-------------------------|-------------------------------|
| Physician/ Madical Examiner | | Registrar | | | | | | 2. Date of Death Month Day Year | | | | | | |
| | | Scott Berman | | | | | | | January 25, 2012 | | | 10 hrs | | |
| | 4 | la. Facility Name (if not institution 18329 Hallmark Court | | | | . City, Tov Gaither | | cation of | Death | 4c. County of Death Montgomery | | | | |
| | ١, | Social Security Number | 6. Sex | 7. Age (In yrs. | | If Under | | If Under : | 24Hrs | 8. Date of Bir | | | rtholace | (State or |
| Funeral Director | 1 | | | 7. Age (III yis. | | Months | | Hours | Min. | 08/26 | | Forei | gn | New York |
| | H | 158-40-8428 January Residence of Decedent | 1 X M 2 F | 0 | Z Yrs. | | | | | 08/20, | (1747 | | 7, 1 | 100 707010 |
| h | - | 0a. State 10b. County | | 10c. City | , Town or Locatio | n | | | | | | | | nside City Limits |
| show | × Μ | aryland Mon | tgomery | | | | Gai | thers | bur | 3 | | | 1 | Yes 2 X No |
| the Maryland n or 28a-f sh | ן פֿבּ | 0e. Street and Number | | | | 10f. Zip C | | | | 1 | 0g. Citizen o | What Cou | intry? | |
| th the Maryland 23s or 28s-f she motified at once | | 18339 H | ullmark | Court | | | | 0879 | | | | | S.A. | |
| r death with or items 23 must be no | 1 era | Marital Status Never Married 2 Ma | A | ecedent Ever in U Forces? | | Decedent s, specify (| | | | cify Yes or No ican, etc.) | | ace - Ame Vhite, etc. | rican In | dian, Black, |
| er dea | | 1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: | | | | | specify: | | | Spec | ity: Cau | cas. | ian | |
| urs aff tural" mine | ଣ⊢ | or Dates: 15 Decedent's Education (Specify only highest grade completed) 16 Decedent's Usual Occupation (Give kind of work done) | | | | | | | 16b. Kind of Business/Industry | | | | | |
| 72 ho | | Elementary/Secondary (0-12) | College | (1-4 or 5+) | | | • | | se retire | d) | | . , | | . |
| 5-0036 led within 72 Hygiene. other than the Medical | Completed | | | 2 | Re | estau | | | | | | Food | Ser | vice |
| filed v Hygi | | 7. Father's Name (First, Middle, | | T Datum | w | | 18 | .Mother's | | First, Middle, I | | | :++ | |
| 21215-0036 uld be filed within 7 Mental Hygiene. ervent, the Medica | | 9a. Informant's Name/Relations | | J. Berma | LYL 19b. Mailing. | Address | (Street a | and Numb | ر er or Ru | OUCE E | nber, City or | Town, Stat | e, Zip C | ode) |
| at is a sh | Ī | Joyce Reisman | | | 7 | | | | | West | Palm I | Beach. | .FL | 33412 |
| w x | | 20a. Method of Disposition | | 20b. | Place of Disposit | ion (Name | | | | Date | 20c. Locati | ion - City o | r Town, | State |
| Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr | - 1 | 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other Sc | | Ft. | . Lincol | n Cre | mate | oru | 01/3 | 1/2012 | Brev | rtwoo | d. N | laryland |
| alti mit. spartm iporta | _ | 21. Signature of Euneral Service | | 20 / | 22. Na | me and A | dress o | f Facility | Simp | le Tri | bute 1 | uner | al 8 | Crem. |
| | 1 | 31 MM | NO | 244 | Ctr | 10 | 140 1 | Rocki | ill | e Pike. | . Rock | ville | , M | D 20852 Proximate Interval |
| Physician Medical | Failure. List only one cause on each line. Between | | | | | | | | | | | | ween Onset and Death | |
| immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate a. Contact Gunsnot Wound of Head Due to (or as a consequence of): b. Due to (or as a consequence of): | | | | | | | | | | + | | | | |
| | | | | | | | | | | | - | | | |
| | | | | | | | | | | | | | | |
| (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | | | | |
| oe executed ician and irial - transit | | - Linesuper | AMENDED #4a per me,g924,02/22/2012dhb 28f.per me,g925 3-8-12 sm | | | | | | | | | | | |
| O, e be ex ysician burial | <u> </u> | UNPENDED | | | | $\frac{0272}{2 \text{ sm}}$ | | J1 ZU11 | | | 23d Dat | e of delive | <u></u> | |
| Box 68760, e death certificate be the attending physic ed for use as the burr | | F FEMALE: 3b. Was decedent pregnant in the past 12 months? | | s, outcome of pre birth | | il death | 3 | Ectopic p | oregnand | Э | Mon | | Day | Year |
| eath cer attendi | SICI | | | gnant at time of o | leath 5 Oth | er (Specif | n) | | | | ï | | | |
| the de | ב ב | Part II. Other significant condit | 9 Olik | nown to death but not | resulting in the un | derlying c | ause giv | en in Part | I. | 23e. Did to | obacco use c | ontribute to | the ca | use of death? |
| ires that the signed by the detache | 6 | 200 | | | | | | | | 1 Ye | s 2 🔽 No | 3 Pro | bably | 4 Unknown |
| ords, w require s been si should b | ete | | | | | | | | | 24a. Was | | | | findings available |
| cor e law r e has t | 24a. Was an autopsy performed? 1 Ves 2 No. 25 No. 25 No. 26 No. | | | | | | | death? | prior to completion of cause of death? 1 Yes 2 No | | | | | |
| 9 1 2 2 8 8 7 7 8 9 8 9 9 9 9 9 9 9 9 9 9 9 9 9 | | | | | | | | f Death (C | heck or | | 2 | | - | 2 |
| Vita ysicia ysicia his cel direct | 0 26 | examiner? 1 ✓ Yes 2 No | Hospital: 1 | Inpatient 2 | ER/Outpatient | 3 DO | A O | ther ₄ | Nursing | Home 5 | Residence | 6 🗸 Oth | er: Scen | е |
| of ng Ph | | 27. Manner of Death | 28a. Da | te of Injury th, Day,Year) D: | 28b. Time of In | · | | at Work? | I۹ | 8d. Describe ubject sho | | curred | | |
| ion frendi leath. | 를 | Natural 5 Pend 2 Accident Inves | stigation Jan 25 | 5, 2012 | FOUND: 1502 hrs | | | s 2 🗸 N | 40 | | | | | -10 |
| 286. Place of Injury - At home, farm, street, factory, office building, etc. | | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| ospita hours y fille | | 4 Homicide determined (Specify) Patio determined (Specify) Patio allmark Court, Gaithersburg, MD 29a. Certifier 4 Court, Gaithersburg at the time date and place and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| Divis To the Hospital or 4 within 24 hours after to the Funcaral Dive completely filled in b | rg | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) | | | | | | | | | | | | |
| To with | Ž. | 29b. Signature and title of certifie | and manner | stated. | | 29c. | icense | number | | | 29d. Date | signed (M | onth, Da | ay, Year) |
| | | (a de | Hell | lan | | | O.C.M | .E. | | | January | 26, 201 | 12 | |
| 2 | 3 | 30. Name and address of person | | | | | | | | | | | | |
| | Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | | | | | | | | | | | | | |
| Sta Registra | _ | 31. Tate Bd Molth, 2017 (bar) | Denew 32 | Registrar's Signa | TE CO | | | | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04591 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Brown trancine 2012 Medical CPLMOL. 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death The Johns Hopkins Hospital Baltimore Birthplace (State or Foreign Country) 8. Date of Birth **Funeral Director** 1 □ M 2 🕱 F 56 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** notified Baltimore 1 Yes 2 No ь 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be 21213 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. 10 ģ 3altimore, Maryland 21215-0036 Black 1 Yes 2 No "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) 27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. ever Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First. မ Cis Gaines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1827 Baltimore, MD Wolfe other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other, Date Department of H Important; If ite any injury or ot once. 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 15/2012 Baltimore of Funeral Service Licenses 22. Name and Address of Facility Harch F/H-East 23a. Part 1. Enfer the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiác or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) rapia Medical Due to or as a consequence of): Examiner Sequentially list conditions Examine Due to or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Yes 2 🗌 No 9 W Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2: autopsy death? 2 No 1 Yes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural
2 Accident 28b. Time of Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred To the Hospital or Attending 5 Pending injury Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) RES-000 2012 FLOTUATY

DHMH 17 Rev 06-2011

State Registrar Souvik

31. Date filed (Month, Day, Year)

600 N. Wolfe

St Baltimore Maryland 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

99

Registrar's Signature

Chatteri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:40 PM FAIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TRANSITIONS HEALTH CARE SYKESVILLE CARROLL 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 Months Hours Min. VE W Director JERSEY Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MI AIRY 1 🗶 Yes 2 🗆 No CARROLL 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ortant If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be Funeral RINGE 6411 21771 USA Was Deceue... Armed Forces? Ves 2 No 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) BAK ELECTRONICS Department of Health and Mental Hygien Important: If item 27 is marked any injury or categorians. CRETAR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KINGEROAN AIRY 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 117/2012 4 Donation 5 Other (Specify) WINFIELD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN ZUMBWN FH & MON Co-21784 23a Jarry . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ O BSTRUCTIVE PULMONARY CHRONIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, second to minimizate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a sonsequence or): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ONGESTIVE HEARI 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending injury work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defining hysterian to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) DS77 22 M-D FEBRUARY 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar RICH

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GREENE TREE ROAD # 300 PILLESVILLE MD 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 04593 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 14^{ay} Douglas Bailey 20^Y2 Emerson 22:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchirst Hospice If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours 228-24-1235 Director 1 XM 2 🗆 F 09 17 26 85 Usual Residence of Deceder 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Catonsville 1 Yes 2 X No MD Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ò pe Funeral 23a 21228 U.S.A. 5721 Edmondson Ave must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc ò ō 1 Never Married 2 Married 1 X Yes 2 No Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: "natural" 3 X Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Balto. City Dept. and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) event, the 12th grade Social Services Case Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ella Sample John Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2813 Lindin Way, Woodstock, Md 21163 Health i Deborah King-Daughter or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Park <u>2/20/2012 Woodlawn, Md</u> Memorial Kina 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Funeral Service Licen Signa Baltimore, Md Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Interval Between Imme Tife Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or in that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 🗋 Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) le Hospital or Attending Pl n 24 hours after death. le Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check fo the within ? only on 29b. Signatur Nitle of cer 1821500G Name and address of person who completed cause of death (Item 23a) (Type,

State Registrar 1050

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** BARTKOWIAK PM HELEN 20:38 FEBRUARY 2012 14 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Apr 2, 1919 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 ₽ F 212-09-6865 Yrs **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eyaminor must be accessed. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md. Baltimore City 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 803 South Streeper Street 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 XWidowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6th Garment Worker Clothes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wladyslaw Wladkowski Emilia Maliszewski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) <u>John B.</u> Bartkowiak, Jr. Windemere Parkway Phoenix, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place)
St.Stanislaus Cem 20a. Method of Disposition 20c. Location - City or Town, State February 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 18,2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee M00933 Tholas <u>Dundalk</u> <u>Avenue Baltimore, Md 21222</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHULANGITIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and the burial-tra resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 🗌 Fetal death 3

Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) has been signed by the a 1 TYes 2 **X**No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ should be 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 X No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death Check on one Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) or Attending 1 🗹 Natural ours after death.

eral Director: At 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral C

completely filled the Hospital

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Arvand

FEB 1

DHMH 17 Rev 1/2001

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 14, 2012

4940 Eastern Avenue, Baltimore, MD, 21224

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pandey,

<u>K</u>.

12-01326

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 04595 Sheri L. Burkhart 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 14, 2012 1207 hrs Medical Examiner Burkhart Sheri 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 2334 Ruskin Ave BrDate of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 1 k 6. Sex **Funeral** Months Oavs Hours 1970 Fermsylvania Director 42 Yrs 1 M 2X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County 1 X Yes 2 No Baltimore City 28a-f show Md. hours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21217 2334 Ruskin Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No 1 Yes White 1 Yes 2 No specify: Specify: If Yes, Give Year 3 Widowed 4 Divorced ð 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n
injury or other traumatic event, the Medical E. Elementary/Secondary (0-12) 721 Sales 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Berry Jay H. Burkhart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>Pennsylvania 18612</u> Emily Lane Dallas, Jay H. Burkhart / Fat<u>her</u> 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) February 1 Burial 2 X Cremation 3 Removal from State |Baltimore,Maryland 17,2012 4 Donation 5 Other Specify: Bayview Crematory 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funer Service Licensee M00933 1201 Dundalk Avenue Baltimore 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line. Death /Medical Pneumonia complicated by Methadone Use Immediate Cause (Final disease xaminerگ or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and AMENDED 23a, 27, per me, g926 4-26-12 sm ian/Medical X UNPENDED ending physician use as the burial the Huspital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Oay 23b. Was decedent pregnant in the Month Live hirth Fetal death past 12 months? Pregnant at time of death 5 Physici 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 ✔ Unknown ğ Completed 24b. Were autopsy findings available 24a. Was an this certificate has been a director, page 2 should prior to completion of cause of performed? death? Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical B Other₄ Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred After the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No within 24 hours after deam.

To the Funeral Director: A Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie February 15, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Melissa Brassell, MD

OCME

ORIGINAL

2. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 8:10 PM Robert Stephen Callen FEBRUARY 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) **Director** 1 XM 2 - F 206**-**26-6817 82 Sept 9, 1929 Maryland Usual Residence of Decedent 28a-f shov 10b. Count 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director Baltimore Timonium 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 2 Ballindine Ct #102 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 🗆 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) real estate real estate injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frank Callen Mary Lamont 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Ballindine Ct #102; Timonium, MD 21093 Betty Callen - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 22. Name and Address of Facility State Anatomy Board Mrector 655 W. Baltimore St; Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ UVO 50 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a nonsequence of burial-tra Due to (or as a consequence of) ending physician use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year the the ed by tl detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has b director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 UNO ပ္ 1 Tyes 1 Finpatient 2 -ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No within 24 hours af er deat

To the Funeral Director:
completely filled i by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

that the death certificate be P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 06-2011

Medical

29a. Certifier

29b. Signature and title of certifier

KoLuardo

North Charles Street Baltimore 6701 ralcon 31. Date filed (Month, Day, Year)

M D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00060721

29d. Date signed (Month, Day, Year)

14

2012

rebruir

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Physician/ Levi Chaplin 0050 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical center wicomico alisbun 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min Director 577-54-0573 73 1 XM 2 □ F 05/30/1938 South Carolina Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Yes 2 No Wicomico Salisbury 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 413 Bailey Lane 21801 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give □ Q ■ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 58 - 59Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 years Landscape Contractor Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Suber Levi Chaplin, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel Chaplin/ Wife 413 Bailey Lane; Salisbury, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State netery, crematory or other place) XBurial 2 Cremation 3 Removal from State Md. 2/29/2012 Cheltenham, MD. Veteran Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signa of Funeral Service 4594 Beech Road; Temple Hills, MD 20748 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed has 2 1 Yes of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) : After this e funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division eral Director: A filled in by the fu 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 30. Name and address of person who completed cau death (Item 23a) (Type, Print) SHORE 910 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Month 2 Physician/ RUE 2812 0745 M 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 217-20-4174 1 🗆 M 2 😾 F 87 Nov 30 1924 South Carolina Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2783 Marshy Pt. Lane 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Force Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No 1 Yes 2 No Specify: If Yes Give white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) accountant manufacturing co Be 17. Father's Name (First, Middle, Last)
Robert Copes 18. Mother's Name (First, Middle, Maiden Surname) ပ Minnie Hunt. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2783 Marshy Pt. Lane Pasadena MD 21122 19a. Informant's Name/Relationship (Type, Print)
Charles B Crue spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 2/20/2012 Pasadena MD. Signature of Funeral Service 22. Name and Address of Facility Stallings Funeral Home P.A. <u>3111 Mountain Road Pasadena MD 21122</u> 23a. Part 1. Enter the disease, or conshock, or heart failure. List only inplications that caused one cause on each line. interval Between Onset and Death Immediate Cause (Final ES Phylician AILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner FIBROSIS MONTHS Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? certificate has performed 2 🗆 No 1 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after thin 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 7 29b. Signature and title of certified

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 Physician/ Ethel Curtis 19:35 PM 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex **Funeral** Months Min (Month, Day, Year) **Director** 91 217-22-1495 1 🗆 M 2 🗶 F 20 SC 29 06 Usual Residence of Decedent 28a-f show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director X Yes 2 □ No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21230 1206 Bayard Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker House 4th grade permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Ethel Austin Henry Canty McFadden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2611 Lauretta Ave, Baltimore, Md 21223 Henrietta Curtis-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Maryland National 2/22/2012 Laurel, Md 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 3a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ongestive Heart Failure Sequentially list conditions Examine cause. Enter Underlying
Cause (Disease or injury Consequence of Renal Fail that initiated events resulting in death) Last Due to (or as a consequence of): physician ar Physician/Medical Box 68760 inding p IF FEMALE yes, outcome of pregnancy ☐ Live Birth _2 ☐ Fetal death _3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Pregnant at time of death signed by the at P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been signated by the second of Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsy performed? Yes 2 No 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie P25587 2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Andrew Window

32. Rg

22 S. Greene St, Bultimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Antonio Carter Donnell 2 2012 6:00a 02 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 00,79 1615 Four Georges Court AptB-3 Dundalk Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 219-02-1486 28 **Director** 18 ΜĎ Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Dundalk 1 Yes 2 XNo MD Baltimore 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 21222 U.S.A. 1615 Four Georges Court AptB-3 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1X Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black CarTer Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Unemployed Unemployed na permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymon Carter Mary Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 21222 615 Four Georges court Apt B-3, Dundalk 19a. Informant's Name/Relationship (Type, Print) 1615 Four Georges court Apt B-3, Mary Taylor-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/20/2012 Zion Baltimore, Md 21. Signature of Funeral Service Licer March and Address of Facility 4300 Wabash Ave, Baltimore, 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asphy Ph. silian/ disease or condition Medical resulting in death) Di to r as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to for as a consectionne offcause. Enter Underlying burial-transi Cause (Disease or linjury that initiated events resulting in death) Last physician and Due to (or as a consequence of): Physician/Medical Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ρğ Month Day Year Pregnant at time of death 5 Other (specify) led 1 the Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed plnous pe**e**n 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has certificate 1 Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: Other: 1 X Yes 2 🗌 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Suicide 28c. Injury at work?
1 \(\subseteq \text{Yes} \) Certificate: injury 1 Natural 5 Pending 600AM Hanging Investigation 14/2012 Accident 28f. L'cation (Street and Number or Rural Route Number, City or Town, State) (61) Four Georges C7 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined tome Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number February 14,2012 30. Name and address of person who completed cause of death (Item 2Ba) (Type, Print) MD 32. Registra Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - For State Registrar

| | 1. | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year 3. Time of Death | | | | | | | | |
|---|----------------|--|--|--|--|--|--|---|----------------------------|--------------------------|-----------|--|
| Physici /Medic | | ALICE | CLARICE | | CAREY | | FEBRUA | | | 9:30 | P | |
| Examiner | | 4a. Facility Name (If not institution, give stre | 4b. City, Town, or Location of Death 4c. County of | | | | | | | | | |
| 2 | ,38 | MANOR CARE NURSIN | | | SILVER | | | | GOMER | | | |
| Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. Ia | ıst birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day | (, Year) | | place (State o intry) | r Foreign | |
| Director | | Usual Residence of Decedent | 89 | | | | APRIL | 8 1922 | CT | | | |
| laryland show | | 10a. State 10b. County | 10c. City, | Town or Lo | ocation | | | | | 10d. Inside Cit | ty Limits | |
| a-fsh iffed | tor | MD PRINCE GEO | RGE'S B | LADENS | SBURG | | | | | 1 X Yes | 2 🗌 No | |
| ith the M or 28a-f e notifie | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen o | f What Cou | intry? | | |
| 23a ust b | rai | 2501 MUSGROVE ROA | D | | 20710 | | | USA | | | | |
| er de tems | Funeral | Ti. Mariai Olalas | . Was Decedent Ever in U.S Armed Forces? | 3. 13. | Was Decedent of H If Yes, specify Cub | Hispanic Origin? (S ean, Mexican, Puerl | pecify Yes or No- o Rican, etc.) | 14. R | ace - Ameri lack, White | ican Indian, , etc. | | |
| ours after death with the Maryle ral", or items 23a or 28a-f sho Examiner must be notified at | by F | 1 X Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 M No If Yes, Give Year or Dates: | | 1□Yes 2∏No | Specify: | | Spec | eify: B | LACK | | |
| | | 15. Decedent's Educat (Specify only highest grade of | | 16a. Dece | dent's Usual Occup | pation | | 16b. Kind of | Business/li | ndustry | | |
| ⊒ | Completed | (Specify only highest grade of Elementary/Secondary (0-12) | ompleted) College (1-4or 5+) | (Give life. | kind of work done DO NOT use retire | during most of world) | rking | | | | | |
| e filed withi al Hygiene. other thar vent, the IV | Con | 12th | , | | BAR-M | | | | RIVAT | E | | |
| be file tal Hy d oth | Be | 17. Father's Name (First, Middle, Last) | | | | | ne (First, Middle, | Maiden Surn | ame) | | | |
| 2 should be a nand Mental is marked o raumatic eve | <u>٩</u> | CHARLES CAREY | | T | | SARAH | KERR - | | | | | |
| 12 sh h and 7 is m traum | | 19a. Informant's Name/Relationship (Type NICHELLE JONES/GRA | , | | | and Number or Ru AVENUE # | | | | . , | 2091 | |
| ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 is marked othe or other traumatic event, | | 20a. Method of Disposition | | | osition (Name of matory or other pla | | Date TAKO | 20c. Location | | | 2091 | |
| ë = ; € | | 1 ☐ Burial 2 【Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify) | noval from State | | matory or other pla LE CREMAT | | 6/2012 | | • | | NT) | |
| | - | 21. Signature of Funeral Service Licensee | U V | | | ess of Facility J. | | | | MARYLAN HOME | | |
| permit. Departr Imports any Inju | | 1) anhmous N. | Granelia | | | OVER ROAL | | | | | | |
| | | 23a. Part1. Enter ne disease, "complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lis only one cause on each line. Approximate Interval Between | | | | | | | | | | |
| Physician | | Immediate Cause (Final disease or condition MD CARANT AL INFACTION | | | | | | | | | | |
| 1 /Medical | | resulting in death) | Due to (or as a consequ | ence of): | 11.11.16 | | | | - | | | |
| Examiner | | Se wentially list conditions b. | HYPERIE | 7640 | rj. | | | | _ | | | |
| sit ed | Examiner | Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequent | | 611 51 | | | | | | | |
| ecute and I-tran | xam | Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of): | | | | | | | | | | |
| ate be executed hysician and the burial-transit | | | | | | | | | | | | |
| ficate physis the | edic | a | 7.77 | | 1) (101) | | | | | | | |
| death certificate be executed e attending physician and of for use as the burial-transi | cian/Medical | IF FEMALE: 23b. Was decedent pregnant 23c | . If yes, outcome pf pregnar | | 75-4 | | | 23d. [| Date of deliv | very | | |
| | icia | in the past 12 months? 1 ☐ Yes 2 🛣 No | ⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _ | . У | | Month Day Year | | | | | | |
| | Physic | 9□Unknown 9□Unknown | | | | | | | | | | |
| The law requires that the date has been signed by the bage 2 should be detached | by P | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par | | | | | 23e. Did tobacco use contribute to the cause of death? | | | | | |
| equir | | | | | ′es 2⊠ No | s 2⊠ No 3 Probably 4 Unknown | | | | | | |
| 2 as a | Completed | | | | 24a. Was autop | psv prior to completion of | | | available ause of | | | |
| The cate has page | Con | | | | | | perfo 1□ Yes | rmed? 2⊠ No | death? | 2 □ No | | |
| ysician: Th is certificate director, pag | Be (| 25. Was case referred to medical examiner? | spital: | ER/Outpatier | O# | 26. Place of Dea | ath (Check only o | ne) | | | | |
| Phys this ral dir | 2 | 1 Yes 2 No | 4,851 Nursing F | sing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred | | | | | | | | |
| ding Ph h. After th funeral | ion | 1 ☑Natural 5 ☐ Pending | of 28c. Inju Wo M 1 | Edd. Describe 1 | resemble new injury securiou | | | | | | | |
| Atten death octor: | fica | 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| al or after | Certification: | 4 Homicide determined building, etc. (Specify) | | | | | | | | | | |
| bours hours unera ly fille | alC | | ian: To the best of my know | | | | | | | | -\ | |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. | edical | (Check only 2 Medical Examine | r: On the basis of examinati and manner stated. | ion and/or ir | | | urrea at the time, | aate and plac | e, and due | to the cause(s | 5) | |
| To 1 To t | M | 29b. Signature and title of certifier | • | | 29c. Licens | | 29d. Date signed (M | | | | | |
| no Li | | M Starteth | 0 | | 104 | 0771 | | 106KUARY 15,2012 | | | | |
| 181 | | 30. Name and address of person who com | pleted cause of death (Item | 23a) (Type, | Print) | QV 11 Mal | CACE. | DIPT . | 1111- | 11 0 00 5 | 7.73 | |
| | | 31 Partill (Port On Mar) | 32. Registrar's Signat | ure | WOKITT | KANALA | GHEOT | sty 1 | V1176- | Mill . | DIN | |
| Sta | te | TEB 1 7 ZU12 /2. | Jan Hogistal 5 digital | 11.1 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day}1 2012 FEBRUARY 4:00 P PORTIA CROXTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CLINTON PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours NORTH CAROLINA **Director** 1941 577-56-8591 1 □ M 2 🗓 F 70 Usual Residence of Decedent or 28a-f show notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be Funeral 20735 USA 8600 MIKE SHAPIRO DRIVE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc ö þ 1 X Never Married 2 Married Maryland 21215-0036 within 72 hours after BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12TH DOMESTIC SERVICE GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ျ JOHN J. CROXTON LEONA L. ABBOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12801 LOST LAKE CIRCLE FT. WASHINGTON, MARYLAND SHERON HARRIS/SISTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 2/18/2012 LANDOVER, MARYLAND J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 22. Name and Address of Facility LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Error the diseased or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year ☐ Pregnant Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 After this certificate has autopsy performed? death? Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 400 Other: 1 Yes မ 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes ☐ Accident ☐ Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Luilding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) ertitying Nurse owledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature a

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February George Henry Chetelat P^{M} 2012 9:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Calvert Prince Frederick Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral T**M 2 □ F Months Days Hours 219-18-4676 Director 87 December 10,1924 Maryland Usual Residence of Decedent or 28a-f show of Health and Mental Hygiene. item 23a or 28a-f shor item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Dundalk 1 🗌 Yes 2 🔀 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 3006 Liberty Parkway 21222 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: Completed 3 ₩ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th 12 years Letter Carrier Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Henry Joseph Chetelat Anna Marie Rhinehardt and 2 should b Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Chetelat 11229 W. Tammy Drive, Bishopville, Md. 21813 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot February 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 25, 2012 Signature of Funeral Service Licensee Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final -Ph_, sician SEPSIS disease or condition > Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-t Physician/Medical Box 68760 attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown P.O. Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ UROSEPSIS Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed RENAL FAILURE Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? death? DEMENTIA STAGE certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ျှ 1 Skinpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔀 Natural work' 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗌 No within 24 hours after death

To the Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 50653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851 Road MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 **FEBRUARY** 6:45 A GLORIA CAMPBELL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) 8. Date of Birth Social Security Number 6. Sex **Funeral** Months Days Hours Min JAN 13 1943 BAHAMAS **Director** 1 □ M 2**X**□ F 578-64-5142 69 Usual Residence of Deced 28a-f show 10b. County aţ 10a. State 10c, City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 √ Yes 2 □ No NEW CARROLLTON PRINCE GEORGE'S MD 9 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral USA 5933 89th AVENUE 20784 or items death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE ENTREPRENEUR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental fitem 27 is marked ဂ LUCY DAMES NATHANEL SMITH 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GABRIEL I. CAMPBELL/HUSBAND 5933 89th AVENUE NEW CARROLLTON, MARYLAND 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/15/2012 BRENTWOOD, MARYLAND LINCOLN CEME. 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 hter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. 23a. Part 1. E Approximate Interval Between Onset and Death Immediate cause (Final disease or condition .Ph_,si_ian Sulduri Medical resulting in death) Due to (or as a consequence of) Examiner Multiple day Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last artendi g physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 Wo
9 Unknown Month Day Year Pregnant at time of death Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 2 🗀 No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 Yes ည ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) to0)0482 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Goulet

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 2 VIN2 2012 0 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sinai Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min, 5. Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** o S As N.Carolina 83 **Director** 242-44-7218 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant If flem 27 is marked other than "natural", or items 23a or 28a-f shoo ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2095 Rockrose Ave. 21211 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 ₩idowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Receiving <u>Reads Drugstore</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David J. Capel Willie Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other trong once. Samuel Capel(brother) 10397 Bluearrow Ct., Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 02/22/12 Owings Mills, MD 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death. the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has d in by the funeral director, page 2 of performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Hospital 24 hours Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2/201

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ELIZABETH Physician/ Month O DARROW Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arundel Anne Genisis Elder Care Severna Park 5. Social Security Number 8. Date of Birth (Month, Day, Y Jan 29 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Year, 217-26-3135 **Director** 1 🗆 M 2 🖼 81 1931 Maryland Usual Residence of Decedent 28a-f show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Anne Arundel Severna Park 10e. Street and Numbe 10f. Zip Code 10a, Citizen of What Country? Funeral 284 Wilderness Road 21146 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced Completed white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home Aid Co Dept Soc Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Hasson other traumatic Mildred Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s at of Health a: If item 27 i Renee Bear daughter 284 Wilderness Road Severna Park MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If ii any injury or or 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State Elkridge Maryland 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cem 2/17/2012 21. Signature of Funeral Service 22. Name and Address of Facility Stallings Funeral Home P.A. dena MD 21122 adena MDi 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Jucely Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year detached Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe After this certificate Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending s after death. 2 Accident
3 Suicide M 1 🗌 Yes Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined building, etc. (Specify) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 13, 2012 8:23 A M Margie Virginia Deitz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours **Director** |216-30-8447 1 M 2 X Oct. 12, 1925 Maryland 86 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Fallston Maryland | Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21047 303 Reckord Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian other traumatic event, the Medical Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 ₩idowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Edna Viola Redifer Amos Henry Burton and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Reckord Road, Fallston, MD 21047 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Margie L. Sebekos / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 A Byrial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Services, LLC 2-15-2012 Bel Air, Maryland Sign Jure of Funer 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line CUTE MAKING LEFT CEREBRAL INFARCT Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner HYDNAMY GABOLIM WITH SEVERE ITY POXIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CUTE MASSIVE Cause (Disease or injury resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 유 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28d. Describe how injury occurred 28c. Injury at To the Hospital or Attending Natural injury work?
1 Yes 2 No 5 Pending Division Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number ☐ Homicide determined within 24 hours a 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) le 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. ANUSHA. SIRITHARA 260 CATEWAY DRIVE, SMITE 21/22B, BELGIR, MD 21014 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #% Per INF G929 //10/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year 12:39 PM Ina Griffin Dawson 2012 ebruary 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAI BAltmore HOSPITAL BAltimore Cil N/A If Under 1 Year __ If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign 2165-92×8018 **Funeral** 1 🗆 M 2 😿 F Days Months 216-36-8018 Director 74 03/29/1937 Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Funeral Director notified 28a-f 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be 23a 4205 Penhurst Ave. 21215 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ZH th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner. Black, White, etc. Completed by permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any riginry or other traumatic event, the Medical Examinone. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education Social Security (Specify only highest grade completed) Elementary/Seconday (0-12)
12th Grade College (1-4 or 5+) Administration Auditor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cardillo A. Griffin Leona S. Jubilee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Dawson(Husband) 4205 Penhurst Ave., Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 02/17/12 King Mem. Park Baltimore, 21. Signature of Funeral Service Licenses ²Joseph H. of Fillrown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. PANCReatic Immediate Cause (Final disease or condition resulting in death) CANCER Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it can be add a to in a class cause. Enter Underlying Physician/Medical Examiner Due to for as a conse, tience of the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi 82245000 MUS completed cause of death (Item 23a) (Type, Print) SINAI HOSPITA BALTIMORE MP 1-RXG TIZ VEDERI State Registrar

Jaws

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death EBMES Physician/ Teb Medical 4a. Facility Name (if not institution give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Seasons Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Birthpiac Country) 6. Sex Social Security Numbe **Funeral** Months Hours Min (Month, Day, Yea 5-21-1957 219-66-5332 Director 1 🜠 M 2 🗆 F 54 Yrs 28a-f show 10d. Inside City Limits 10a, State 10h. Count 10c. City, Town or Location must be notified at Director 1 Yes 2 No Ranallstown MDBaltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21133 23 Sunrise Court "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Examiner Black, White, etc. by 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: SpecifyAfrican-American Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Greater Joy Ministries Minister permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event ** Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Minner Jean Gilmore Paulette Fames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Sunrise Ct., Randallstown, MD 21133 Denise Eames/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Condition 5 Other (Specify) 2-21-2012 Woodlawn, MD Woodlawn Cemetery 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. O. Ineral Ser 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. Ist only one caus Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumor Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence on Cause (Disease or injury ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No fo Day Pregnant at time of death the Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 autopsy page 2 perform death? Yes 2 No 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 IDOA မှု 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer Natural 5 Pending within 24 hours after death To the Funeral Director: A Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-201:

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| DeAngelo Eberni | | State of Maryland / D 1-For State Registrar | Certificate of Dea | | | 201 | 2 0461 |
|--|----------------|---|---------------------------------------|---|--|---|---|
| Physicia Medical Examir | n/ | 1. Decedent's Name (First, Middle, Lest) Deangelo Eberchart | | | 2. Date of Death Month February 8, | | 3. Time of Death 1605 hrs |
| , | | 4a. Facility Name (if not institution, give street and number) | | y, Town, or Location of Death | | 4c. County of Death | |
| Funeral | | 2416 Ashland Avenue 5. Social Security Number 6. Sex 7. Age (In | | timore nder 1 Year If Under 24Hrs | s. 8. Date of Birth | n(MM/DD/YYYY) 9. Birt | hplace (State or |
| Director | | 219-98-6410 11MM 2 F | 29 Yrs. Mor | nths Days Hours Min | 5-28 | -1982 Foreig | my Aveyland |
| ınd show any ace. | 7 | | City, Town or Location Ballin | none | | | 10d. Inside City Limits 1 Yes 2 No |
| the Maryland Sa or 28a-f show | Director | 10e. Street and Number 2416 Ashland Arc | 2. 10f. z | Zip Code 21213 | 109 | g. Citizen of What Cour | try? |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "matural", or items 33a or 28s-f sho traumatic event, the Medical Examiner must be notified at once. | Funeral | 11. Married Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 | No If Yes, spe | edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto | | 14. Race - Americ White, etc. Specify: | |
| ours afte | <u>a</u> | Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete) | ted) 16a. Decedent's Usu | 2 No specify: | | Specify: 16b. Kind of Business/li | |
| 1036 vithin 72 ho ene. er than "na Medical Ex | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) | | working life. DO NOT use reti | n | Home In | n procenia |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than | Be ငိ | 17. Father's Name (First, Middle, Last) Sohnny Eberhatt | | | (First, Middle, Ma 21A | | |
| D 2121 should be fil and Mental F 7 is marked natic event, 1 | ٥ | 19a. Informant's Name/ elationship (Type, Print) | 19b. Mailing Addre | Ss (Street and Number or I | Rural Route Numb | oer, City or Town, State, | |
| ore, MD is 1 and 2 sho of Health and If item 27 is her traumati | - | Johnny Eberhart 20a. Method of Disposition | 30 02 20b. Place of Disposition (N | TEPN dal | | 20c. Location - City or | <i>M. 21207</i> Town, State |
| More Pages 1 ent of H nt: If i | | 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: | My Carmen | Cemeber 2 | 120/12 | Ballo.1 | nd. |
| Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 | 1 | 21. Signature of Fune of Strice Linese | | nd Address of Faculty | a due | netro pola | or Ma 21/2 |
| Physician /Medical | | 23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. | | le of dying, such as cardiac o | | | Approximate Interval Between Onset and |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Thromb Due to (or as a consequence) | | | | | Death |
| | _ | Sequentially list conditions, if any, leading to immediate | | | | | |
| _ | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated | | | | | |
| cecuted 1 and - transit | | events resulting in death) Last Due to (or as a consequence) d. | nce or). | | | | |
| 60, tte be exer hysician a e burial - r | Medical | UNPENDED AMENDED | | | | | |
| ox 6876(eath certificate attending phy for use as the t | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth | f pregnancy 2 Fetal deat | th 3 Ectopic pregna | incy | 23d. Date of delivery Month D | ay Year |
| Box 687/ death certifica he attending pi d for use as th | Physician/ | 1 Yes 2 No 9 Unknown 9 Unknown | of death 5 Other (Sp | pecify) | | | |
| P.O. E es that the cigned by the detached | b P | Part II. Other significant conditions contributing to death but | not resulting in the underlying | ing cause given in Part I. | | acco use contribute to t | r-errs |
| w requires the seen signal should be a | ted k | | | | 1 Yes | 2 No 3 Prob | opsy findings available |
| 8 a a 2 | Completed | | | | autopsy perform 1 ✔ Yes 2 | y prior to coned? death? | ompletion of cause of |
| ital Reician: The s certificate rector, page | a | 25. Was case referred to medical examiner? Hospital: 1 Inpatient | 2 ER/Outpatient 3 | 26.Place of Death (Check | | esidence 6 🗸 Other: | S |
| on of Vital Perding Physician: ath. br: After this certification. | 밁 | 1 Yes 2 No apparent 227. Manner of Death 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | | w injury occurred | Scerie |
| OT sath. | Į Į | Natural 5 Pending Accident Investigation | | 1 Yes 2 No | | | |
| Division of Vital Rec spital or Attending Physician: The hours after death. oceal Director: After this certificate y filled in by the funeral director, page | Certification: | 3 Suicide 6 Could not be determined (Specify) | - At home, farm, street, facto | ory, office building, etc. | 28f. Location (Str or Town, Sta | reet and Number or Rur ate) | al Route Number, City |
| 2 4 2 > | Medical C | 23a. Certifier 1 Certifying Physician: To the best of my kno (Check only one) 2 Medical Examiner: On the basis of examinat and manner stated. | | | | | |
| F 8 5 0 | ¥ | and marrier stated. 29b. Signature and title of certifier | 2 | 9c. License number | | 29d. Date signed (Mon | |
| | | 20 Name and address of names who as plated from a first the | (Itam 23a) | O.C.M.E. | | February 9, 2012 | |
| | | 30. Name and address of person who completed cause of death Russell Alexander MD. Assistant Medical E | | altimore Street, Baltim | ore, MD 2122 | 23 | |
| Sta Registr | te ar | 31. Date filed (Mooth Day, Year) 2012 22. Registrar's Si | ignature sarks | | | | |
| | _ | 199 | | | | • | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Day}}{2} \underline{0} \underline{12}$ Physician/ Month Feb. Charles F. Franc 12, 11:25 a ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Care Center - Oak Crest Village Parkville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | Sept. | 17, Parkville Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F 86 Maryland Director 217-12-3112 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8834 Walther Blvd. 21234 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Dept. of Housing Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Senior Engineering Draftsman Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Ferdinand Franc Rose Simek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Hejduk 3417 Ady Road Street, MD 21154 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith UNK Balto.Md. 21. Signa Lire of Funeral Service Licensee Name and Address of Facility
Yiller-Dippel Funeral Home, Inc. Road Baltimore. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any Lading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Exami sician and burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical the t attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery Box in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 L 9 Unknown Yes 2 No O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an page 2 Nor certificate Yes 1 Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work? s after dec. 1 Natural injury 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. pleted filled in by determined 24 hours Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination array or investigation, irring opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I RO6734

State Registrar

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRAZIX

8800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $10 2 \overset{\text{Pear}}{012}$ Physician/ FEBRUARY \mathbf{P}^{M} REGINALD GRAYSON JR. 8:28 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 1802 NAPIER DRIVE FORESTVILLE Social Security Number 1 Year If Under 24 Hrs. . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days NOV. 10 1X M 2 □ F Months Hours Min. WASHINGTON DC **Director** 578-82-3121 37 Usual Residence of Decedent 28a-f shov ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S FORESTVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1802 NAPIER DRIVE 20747 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc <u>≨</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 ☐XNo Specify. BLACK Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry ift. Page 1 and 2 should be theo wrum... artment of Health and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th NONE NONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GRAYSON SR. BERNADETTE JACKSON REGINALD 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1802 NAPIER DRIVE FORESTVILLE, MARYLAND 20785 BERNADETTE JACKSON/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of I Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/17/2012 SUITLAND, MARYLAND CEDAR HILL CEMETERY Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Em. r the dise 1, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ASPIRATION PNEUMONIA Medical Due to (or as a consequence of Examiner CEREBRAL PALSY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed SEPSIS sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the buria Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2X No 1 Yes _ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No 1 Yes ρ 4 Nursing Home 5X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA : After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be

Box 68760 P.0. Records, of Vital To the Hospital or Attending Physician; Division within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

State DHMH 17 Rev 7/2009

Registrar

29a. Certifier (Check

only on 29b. Signatu

Medical

determined

ARNULFO BONAVENTE M.D. 6409 SOUTH CRAIN HIGHWAY UPPER MARLBORO, MARYLAND

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D45630

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

son who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

FEBRUARY 15, 2012

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gmurek 16, 2012 John February 10:51 A^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2766 Moorgate Road Dundalk If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Director <u>217-16-489</u>7 1 🛛 M 2 🗆 F 88 August 13,1923 Maryland Usual Residence of De 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Md. Baltimore Dundalk 1 Tes 2 No 50 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2766 Moorgate Road 21222 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner med Forces Black, White, etc. 9 1 Never Married 2x Married 1 X Yes 2 ☐ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2X No Specify. "natural", Specify: White 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Line Supervisor Martins Aviation should be filed with and Mental Hygien ris marked other the 10 vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lucas Gmurek Josephine Fialkowski 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Gmurek Wife 2766 Moorgate Road, Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Februar Rosedale, Maryland Gardens of Faith Cem. 21, 2012 Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licenses 7110 Sollers Point Road, Dundalk, Md. 23a. Pail 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ 25 GUG Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and -transit The law requires that the death certificate be executed Due to (or as a consequence of): -burialattending physician I for use as the buris Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the a 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown been sig should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗆 No 1 Yes Yes 2 To the Hospital or Attending Physician: 25. Was case referred to med Be 26. Place of Death (Check only one) examiner? 1 Yes Other: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify this 27. Manner 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending 1 ☐ Yes 2 ☐ No after death. I Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours af

To the Funeral Di

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 0 se of death (Item 23a) (Type, Print) 301 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HILL FEBRUARY 2012 9:00 A MILDRED Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12606 CROZET DRIVE UPPER MARLBORO PRINCE GEORGE'S Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Director MARYLAND 577-12-6731 SEPT 1917 Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified PRINCE GEORGE'S MD UPPER MARLBORO 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12606 CROZET DRIVE ral", or items a death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Let 15-0036

Learning Page 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natures" any injury or other traumatic power. Black White etc. Completed by 1 Never Married 2 Married 2 X No Yes 1 ☐ Yes 2 X No Specify: If Yes Give BLACK 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ TEACHER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 OSCAR WATKINS NAOMI WILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA MCCANTS/NIECE 12606 CROZET DRIVE UPPER MARLBORO, MARYLAND 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, LINCOLN CEMETERY Donation 5 Other (Specify) 2/18/12 SUITLAND, MARYLAND Signatur 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ COMPLETE HEART BLOCK disease or condition) Medical resulting in death) Due to (or as a consequence of): **Examiner** SEVERE PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury BILATERAL LEG ISCHEMIA attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of):

CORONARY ARTERY DISEASE resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: ase s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 K No Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 X 9 Unknown the signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, DIABETES MELLITUS 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION certificate has autopsy performed ALZHETMER'S DISEASE Yes 2 ▼No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No 1 Tes Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death nours after death.

neral Director, After the filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital within 24 hours a To the Funeral C completed filled Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) M D34445 FEBRUARY 15, 2012

Registrar
DHMH 17 Rev 7/2009

State

FRANCISCO KING M.D. 106 IRVING STREET N.W. WASHINGTON, DC 20010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 CL

| | | | ease i | | | | d / Dep | | | | | | | | gibie. | |
|--|-------------------|--|--|-------------------------------------|--------------------------|------------|----------------------------------|-------------------------|---------------------------|----------------------|----------------------------|---|------------------------------|--------------|---|---|
| | ľ | For State Registrar | | Olalo | JI IVIQI | ylali | | | te of E | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 1. No. 2 | 012 | 01.61 |
| | п | Decedent's Name (First, Min | ddle, Last) | | | | | | | | | | of Death | i- | U + (| 3. Time of Death |
| Physicia Medio | | 412212 | 1 | 4 6 | Hop | 17. | ~ ` | | | | | Mont | h پو-ادا و پرد | Day 5 | Year | 5:20cM |
| Examin | | 4a. Facility Name (if not institu | | | | | | 4b. City | , Town, or | Location | n of Death | | | | nty of Death | 1 |
| <i>f.</i> | d | worthwast | - lte | 50-1-1 | | ~ + ~ | | | mAr (| | | | | 10 | ct - ma | ~~ |
| Funeral | 1. | 5. Social Security Number | 6. Sex | | 7. Age (/ | In yrs. la | ast birthday) | If Und | er 1 Year Days | If Und | er 24 Hrs. Min. | 8. Date ((Mont | of Birth h, Day, Ye | ear) | | hplace (State or Foreign intry) |
| Director | | 238-78-4826 Usual Residence of Deceder | _ | M 2 Z F | 6 | 5 | Yrs. | | | | | No. | ی ر | - 194 | 6 | NC |
| and show | or | 10a. State 10b. Cou | | | 1 | 0c. City | , Town or Lo | cation | | | | | | | | 10d. Inside City Limits |
| Maryl 28a-f otified | rec | MD 1 | Baltimo | פמכ | | | Pikesvi | 11e | | | | | | | | 1 ☐ Yes 2X No |
| a or a | <u>=</u> | 10e. Street and Number | | | | | | 10f. Z | ip Code | | | | 10 | | of What Co | untry? |
| h with | Funeral Director | 807 Templeclif | | | | | | <u>.</u> | | 1208 | | | | | JSA | |
| r deat r iten iner r | | 11. Marital Status 1 ☐ Never Married 2 🔀 I | | 2. Was Dece Armed Fo 1 Yes | edent Eve | er in U.S | 5. 13. | Was Dece If Yes, spe | edent of Hi ecify Cuba | spanic C n, Mexic | Origin? (Spe an, Puerto | ecify Yes o Rican, etc | r No- :.) | | ace - Amer lack, White | ican Indian, , etc. |
| s afte al", c Exam | d by | 3 Widowed 4 Divor | | I ☐ Yes If Yes, Giv Year or D | ve |) | | 1 🗌 Yes | 2 X No | Specia | fy: | | | Speci | _{ify:} At | Frican-America |
| hours natur lical | Completed | | edent's Edu | cation | | | 16a. Dece | | | | - 1 6 - 1 | | 16 | b. Kind of | Business/I | ndustry |
| in 72 e. han " | Juc | (Specify only his | | College (1 | | | life. D | O NOT us | se retired) | | ost of work | ing | Ι. | | | a. 11 616 |
| d with ygien her ti nt, the | Be C | 12th | | | | | Data | Entry | Clerk | - | | | | | | reShield of M |
| e filec ntal H ed ot ever | To B | 17. Father's Name (First, Midd | e, Last) | | | | | | | 18. Mo | ther's Nam | e (First, Mi e Brool | | den Surna | me) | |
| d Mer d Mer mark matic | | Lacy Jackson 19a. Informant's Name/Relation | anchin (Time | n Print\ | | | 400 14 10 | | | 1.54 | | | | T | Ciria 7ia | 0-3-1 |
| 2 shouth and the shou | | | _ | | | | | _ | | | Baltim | | | | , State, Zip | Code) |
| 1 and f Hea item other | | Anika McCready/ D 20a. Method of Disposition | 0 | | | | lace of Dispo | sition (Na | me of | | | Date 11 | | | n - City or | Town, State |
| Page nent o int: If iry or | | 1 ☐ Burial 2 ☐XCremat 4 ☐ Donation 5 ☐ Othe | on $3 \square R$ er (Specify) | Removal from | State | | emetery, crei o Cren e | | other plac | e) | 2-20-2 | 2012 | B | altimo | re, MD | |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Funeral Servi | | 1 | | | 22 | 2. Name a | nd Addres | s of Fac | ility W1: | ie Fun | eral I | tame P | .A.of | Baltimore Co. |
| 9.3 E E 6 | | 1 Und 1 C | 6 | 21 | | | 92 | 200 Li | berty | Road | Rand | allsto | wn, M | 2113 | | |
| | | 23a. Part 1. Enter the disease shock, or heart failure. L | , or complications on the contract on the complex of the contract of the contr | cations that of cause on ea | caused th ach line. | ne death | n. Do not ent | er the mo | de of dying | g, such a | as cardiac | or respirato | ory arrest, | | | Approximate Interval Between |
| Physician/ | | Immediate Cause (Final disease or condition | _ a | Se | orasa c | 20 | n-en | | | | | | | | | Onset and Death |
| Medical Examiner | | resulting in death) | | Due to | (or as a c | onsequ | ence of): | | | | | | | | | |
| | ıer | Sequentially list conditions, if any, leading to immediate | b | | (or as a c | | | | | | | | | | | |
| ted 3 ansit | Examiner | cause. Enter Underlying Cause (Disease or injury | 5 | | ٠ | | | | | | | | | | | |
| be executed sician and burial-transit | | that initiated events resulting in death) Last | | | (or as a c | | | | | | | | | | | |
| te be nysicia he bu | dical | | d | | | | | | | | | | | | | |
| eath certificate b attending physi d for use as the k | by Physician/Medi | IF FEMALE: | | | | | | | | | | | | | | |
| ith cei ittend for us | ian/ | 23b. Was decedent pregnant in the past 12 months? | 23 | | Birth 2 | ☐ Feta | Ideath 3 | | | y | | | | 1 | Date of deli Month | very Day Year |
| e dea the a | ysic | 1 Yes 2 No | | 4 ☐ Preg 9 ☐ Unki | | me or a | leath 5 L | ☐ Other (S | speciry) | | | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| hat th ed by detac | y Ph | Part II. Other significant con- | litions con | tributing to d | death but | not res | ulting in the u | underlying | cause giv | en in Pa | rt I. | 23e. | Did toba | cco use co | ntribute to | the cause of death? |
| uires t sign uld be | q pa | Congran | L | + Le | 3 | | | | | | | | 1 🗌 Yes | 2 🗌 No | 3 🗆 Pr | obably 4 Unknown |
| v request specifications | olet | | | | | | | | | | | | Was an | 24k | | opsy findings available ompletion of cause of |
| he lante ha | Completed | | | | | | | | | | | | autopsy performe Yes 2 | | death? | 2 No |
| sici an: The law r certificate has b lirector, page 2 s | Be C | 25. Was case referred to medi examiner? | cal | | | | | | 26. Pla | ace of De | eath (Chec | | - | | | |
| Physician: 1 r this certifica eral director, p | 은 | 1 ☐ Yes 2 ☑ No | Ho | - | | 2 🗆 | ER/Outpatie | | Othe | er: 4 🗌 | Nursing Ho | ome 5 🗌 | Residence | e 6 🗆 O | ther (Speci | fy) |
| ling P | ate: | 27. Manner of Death 1 Natural 5 Per | nding | 28a. Date (Mon | of injury oth, Day, Y | (ear) | 28b. Time of injury | | 28c. Injury work | ? | | 28d. Desc | ribe how | injury occu | ırred | |
| ttend death stor: / y the | Certificate: | 3 Suicide 6 Co | estigation uld not be | 280 Place | of Injuny | - At ho | me, farm, str | M eet facto | | Yes 2 | ∐ No | 20f Locat | tion (Stroy | t and Nun | ahor or Pur | al Route Number, |
| lor A after Direct | | 4 ☐ Homicide det | ermined | | ing, etc. (S | | | eet, racto | ry, Ornice | | | | or Town, S | | ibei oi mui | ai moute Marriber, |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the | Medical | | | | | | edge, death | | | | | | | | | |
| he Ho in 24 he Fu pletel | Med | | | | | | and/or inves ny knowledge | | | | | | | | | ause(s) and manner stated s stated. |
| To to | | 29b. Signature and title of cert | ifier | | | | | 29 | c. License | number | r | | 290 | l. Date sigr | ned (Month | , Day, Year) |
| | | augu | | | | | | | 0 | 290 | 185 | | <i>l=</i> | con | · ~ 7 | 15 2012 |
| 10 | | 30. Name and address of pers | | | | | | | | | | | | | | 0.10 |
| Stat | | 31. Date filed (Month, Day, Yea | | 32. R | S 4 | Signat | ure |) (| eun | _ ^ | رمما | - | | - | | 21137 |
| Stat Registra | | FEB 1 7 2012 | Ben | eur) | 1 | ba | ure Vens | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Physician 13, 2012 4:00 Α February Hoffman Elizabeth Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore St. Agnes Hospital N/A 9. Birthplace (State or Foreign Country) Mary Land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 7. 1923 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🗹 F 88 Director 218-18-5829 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director Anne Arundel Linthicum Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō U.S.A. 21090 'natural", or items 23a 566 Forest View Road Funeral 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. It all the many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife & Mother 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola Mae Turner I. Young Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 566 Forest View Road, Linthicum, Maryland 21090 Dolores M. Gauss (Daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 02/16/2012 Baltimore, Maryland Cedar Hill Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee MCully-Polyniak Funeral Home, P.A. 237 Fast Patapsco Avenue, Baltimore, Maryland 21225 John F. Collins MOO-732 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 0 445 Physician KENAL ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and Due to (or as a consequence of): burial-P.O. Box 68760. physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 r Month Day Ye ar 5 Other (specify) 1 ∐Yes 2 ☑ No ed by the a detached f 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No 24a. Was an this certificate has page 2 s autopsy 1 ☐ Yes V director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ပ 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division To the Hospital or Attending 5 Pending investigation 1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated.

Registrar

29b. Signature and title of certifier

30. Name and address of person wh

31. Date filed (Month, Day,

ohn

AnTunia

Wilkens

ompleted cause of death (Item 23a) (Type, Print)

449

D0058226

AUE BAITU. MD.

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ aniel 5:11 2012 0 Medical or Lecation of Death 4c. County of Death 4a. Facility Name (if not institution, give street and 4b. City, Town. Examiner Baltimere 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 № M 2 🗆 F Months Hours SIRCHAIN Director 10c. City, Town or Location 28a-f show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Baltomore 1 Ves 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Dever Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Wechane Co permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) ည dughes 19a. Informant's Name/Relationship (Type, Print) + 10ane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave. 139 Baltimore, of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral 5 / lo Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of and burial-trar Due to (or as a resulting in death) Last attending physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Day Month Pregnant at time of death
Unknown Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records. 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 2 1 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 🗌 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated OL

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Caton

900

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| ony locato | | - For State Registrar | or ivial yland i | | rtificate of L | | and Men | | Reg. No. 201 | 2 0461 |
|--|----------|--|--|-----------------|------------------------------|-------------------|---------------------------|--|--|--|
| Physician Medical Examine | 1 | Decedent's Name (First, Middle,La | | - | _ | | - | 2. Date of De | | 3. Time of Death 1912 hrs |
| MECICAI EXAMINA | | <u>Jerry</u> 4a. Facility Name (if not institution, g | Is a ve street and number) | ıac | 4b | City, Tov | vn, or Location of | | 4c. County of Dea | |
| | Ļ | Johns Hopkins Hospital 5. Social Security Number 6. 6. | - I7 Aa | (loves | last birthday) | Baltimo | | er 24Hrs. 8. Date of B | irth(MM/DD/YYYY) 9. E | |
| Funeral Director | | | XXM 2 F | 22 | Yrs. | Months | Days Hours | 1 201- | Fore | |
| # any | - 1- | 10a. State 10b. County | | 10c. City | , Town or Location | | | | 1 | 10d. Inside City Limits |
| yland I-f shov | <u>.</u> | MD 10e. Street and Number | IA | Ва | altimor | e I Of. Zip Co | ado . | | 10g. Citizen of What Co | 1 X Yes 2 No |
| th the Maryland 23a or 28a-f sh notified at once | | 338 East 26th | | | | 21 | 218 | | USA | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. | Launer | 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce | 12. Was Decedent Armed Forces? 1 Yes 2 | Ever in U No | If Yes | specify (| | gin? (Specify Yes or N , Puerto Rican, etc.) | o- 14. Race - Am White, etc. Specify.A M € | arican Indian, Black, African rican |
| ours after | 2 | 15. Decedent's Education (Specify | or Dates: | pleted) | 16a. Decedent's | Usual Oc | cupation (Give I | kind of work done | 16b. Kind of Busines | |
| 5-0036 ted within 72 hour sygiene. other than "natu | | Elementary/Secondary (0-12) 12th Grade | College (1-4 or 5 NA | +) | | rec | | | McDona | ld's |
| 21215-0036 suld be filed within 7 Mental Hygiene. marked other than te event, the Medica | | 17. Father's Name (First, Middle, Las ${\sf Jerry} \;\; {\sf W.} \;\; {\sf I}$ | - | | | | | s Name (First, Middle, | | n e |
| 212 hould b and Meni is marl | 랅 | 19a. Informant's Name/Relationship | | | 19b. Mailing A | ddress (| Street and Num | ber or Rural Route Nu | ie Holli mber, City or Town, Sta | te, Zip Code) |
| and 2 sho tealth and tem 27 is traumati | | Ruby McCain-G | | 20b | 434 1 Place of Disposition | Iche n (Name | ester A | Avenue Ba | altimore, | MD 21218 or Town, State |
| Baltimore, permit. Pages 1 ar Department of Hee Important: If ite | L | 1XX Burial 2 Cremation 3 4 Donation 5 Other Specif | y: | te K | ing Mem | . Pl | <. | 02-16-12 | Randall | stown, MD |
| Baff permit Depar Impo | | 21 Signature of Funeral Service Lice | nsee | | | | | | uneral Ho Baltimor | me P.A. e,MD 21217 |
| Physician //Medical | Ì | 23a. Part I. Enter the disease, or comfailure. List only one cause on a | | the death | . Do not enter the | mode of c | lying, such as ca | ardiac or respiratory ar | rest, shock, or heart | Approximate Interval Between Onset and |
| Examiner | | Immediate Cause (Final disease a or condition resulting in death) | Multiple Gunsho | | | | | | | Death |
| | | Sequentially list conditions, if any, leading to immediate | Due to (or as a conse | anence c | NF)· | | | | | |
| ted Insit | | cause. Enter Underlying Cause (Disease or injury that initiated | i | | | | _ | | | |
| A cuted Ransit | Ĭ | events resulting in death) Last | Due to (or as a conse | querice d | n). | | | | | |
| 60, ate be exechysician a | 2 | UNPENDED [| AMENDED | | | | | | | |
| eath certificate be executed at a stending physician and for use as the burial - transit | 2 | F FEMALE: 3b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcom | | 2 Fetal | death | 3 Ectopic | : pregnancy | 23d. Date of delive Month | Day Year |
| b. Box 687 the death certific by the attending p | 2 | 1 Yes 2 No 9 Unknow | 4 Pregnant at | time of de | eath 5 Othe | · (Specify |) | | * | |
| P.O. E ires that the d signed by the be detached | 3 | Part II. Other significant conditions | contributing to death | but not r | esulting in the und | erlying ca | use given in Pa | | tobacco use contribute to | |
| Records, The law requires ficate has been sig | biere | | | | | | | 24a. Was | | autopsy findings available completion of cause of |
| tal Rec | | 25. Was case referred to medical | | | | 26 | Place of Death (| 1 Yes (Check only one) | 2 No 1 🗸 | |
| f Vital Physician or this cert ral directo | ă | examiner? 1 ✔ Yes 2 No | | | ER/Outpatient | | Othor - | | Residence 6 Oth | er: |
| Division of Vital Records, P.O. Isal or Attending Physician: The law requires that the stand feath. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted by the funeral director. | | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga | 28a. Date of Inju (Month, Day,Ye Unknown | y ear) | 28b. Time of Inju Unknown | ry 28c | . Injury at Work | Subject shi | how injury occurred of | |
| Division o spital or Attending sours after death. neral Director: After filled in by the fune | | 3 ☐ Suicide 6 ☐ Could no determin | t be 28e. Place of Inj | | ome, farm, street, et | factory, of | fice building, etc | or Town, | | Rural Route Number, City nore, MD |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans | | Contract only | | | | | | | se(s) and manner as sta and place, and due to | |
| | Ě | 29b. Signature and title of certifier | | / | 1.4 | | icense number D.C.M.E. | | 29d. Date signed (M February 14, 20 | |
| 2 | - | 30. Marge and address of person who Russell Alexander MD. | completed cause of de | | 1 / | Baltim | ore Street. | Baltimore, MD 2 | 1223 | |
| Stat Registra | | 31. Peter filed (Maeth Day Vear) | 32. Registrar | | | | <u>'</u> | | | |
| IVER ISH C | 1 | | F1 - 1 - 1 | 11 | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| D'Andrea E. Jackson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Re | | | | | | | eg. No. | 20 | 12 | 0461 | | | | | |
|---|---|---|--------------------------|----------------|-------------------------------------|-----------------------------------|--|-------------------------|---------------------------|-----------------------|----------------------------------|------------------|-------------------------------|----------------------|--|
| Physician/ | | gistrar Decedent's Name (First, Midd | e,Last) | | | | | - | | | Date of Deat | h | Year | 3 | . Time of Death |
| Madical Examiner | Ē | 'Andrea | | | umeki | | | cks | | | Month February 1 | 14, 20 | 012 County of D | | 0953 hrs |
| | 4 | a. Facility Name (if not institution 3001 Branch Avenue | | et and numb | per) | 1 | 4b. City, To Temple | | ocation of | Death | | | rince Geo | | , |
| Eurosal | 5 | Social Security Number | 6. Sex | 7. | Age (In yrs. las | st birthday) | If Under | 1 Year | If Under | 24Hrs. | 8. Date of Bir | th(MM | /DD/YYYY) 9. | Birth | place (State or |
| Funeral Director | 1 | | 1 M | | 54 | Yrs | Months | Days | Hours | Min. | 07 2 | 4 | 57 | coun | try) IL |
| | | 331-54-8216 Isual Residence of Decedent | | | | | <u> </u> | | | | | | | 1 | Od. Inside City Limits |
| w any | 1 | 0a. State 10b. County | | | | Town or Locat | _{lon} Lcres | .+ H | leiah | nts | | | | - 1 | 1 Yes 2 No |
| Maryland 28a-f shood at once. | | MD Princ Oe. Street and Number | e Ged | rges | | 11 1 1 1 | 10f. Zip | | | | 1 | Og. Cit | izen of What (| Countr | y? |
| he Mar iffed at | | 3001 Branch | Ave [| Jnit | 822 | | 2 | 2074 | 8 | | | 1 | U.S.A | • | |
| eath with the Maryland items 23a or 28a-f show ust be notified at once. | | 1. Marital Status | 12. | Was Deced | lent Ever in U.S | i. 13. Wa | as Deceder es, specify | nt of Hisp | anic Origi | n? (Spec | cify Yes or No | - | 14. Race - A White, et | | n Indian, Black, |
| T 181.7 | | 1 Never Married 2 N | 1 | Armed Ford Yes | 2 No | i | | | | 00110111 | , 545.7 | | | | o a le |
| s after nral", | <u>-</u> | 3 Widowed 4 X Dir 15. Decedent's Education (Spe | vorced or De | ites: | completed) | 16a, Deceder | Yes 2 | Occupation | on (Give ki | ind of wo | rk done | 16b. | Kind of Busine | Bla ess/Ind | |
| 5-0036 ed within 72 hour tygiene. he Medical Exar Completed | | Elementary/Secondary (0-12) | | College (1-4 | | during m | ost of work | king life. | DO NOT L | ise retire | d) | | n+ n | e i | Interior |
| 036 ithin 7 and. | | l2th grade | | na | | Adm | in. | | | | | | | <u></u> | Interior |
| 21215-0036 Mid be filed within 72 hours after death with the Maryland marked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at once. | | 7. Father's Name (First, Middle | | | | | | 1 | | | First, Middle, I | | n Surname) | | |
| 2121 Ild be fil Mental I Mental I event, | | Robert Jacks 9a. Informant's Name/Relation | on Si ship (Type, I | Print) | | 19b. Mailin | g Address | (Street | and Numi | ber or Ru | ral Route Nur | nber, (| City or Town, S | State, 2 | Zip Code) |
| MD 2 shouth and 27 is umatic | 1 | Robert Jacks | on J | cBr | | | | | | | | | set, | | 08873 |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after perment. Health and Mental Hygiers. Important: If tiem 77 is marked other than "natural", of injury or other traumatic event, the Medical Examiner. To Be Completed by F | F | 20a. Method of Disposition 1 Burial 2 X Crematic | n 3 R | emoval fron | | lace of Dispo rematory or o | | ne of cem | | | Date | | | | |
| Page ment o tant: | | 4 Donation 5 Other S | Specify: | 1 | | On-Si | | Addrose | | | 3/2012 | 2 B | <u>altim</u> | ore | e, Md |
| Balt Permit. Pepart Impor | + | 21. Signature of Funeral Servic | Licens | ON M | M | M. 4 | Name and arch 300 | Waba | I We | st Ave, | Balt | im | ore, | Md | 21215 |
| Physician | + | 23a Part I. Enter the disease, of | r complication | ons that | used the death. | Do not enter | the mode o | of dying, | such as ca | ardiac or i | respiratory ar | rest, sh | nock, or heart | | Approximate Interval Between Onset and |
| /Medical | + | failure. List only one caus Immediate Cause (Final diseas | е а. Ну ј | perter | sive A | | clero | tic | Cardi | ovas | scular | Di | sease | | Death |
| ZXammer | | or condition resulting in death) | Duet | to (or as a c | consequence of | ·): | | | | | | | | | |
| | | Sequentially list conditions, if any, leading to immediate | | to (or as a c | consequence of | ·): | | | | | | | | | |
| 22, bed mist | E | cause. Enter Underlying Caus- (Disease or injury that initiated events resulting in death) Last | C. | to (or as a c | consequence of | f): | | | | | | | | | |
| e executed cian and mial - transit | ׅ֡֝֟֝֟֜֞֜֝֟֝֟֜֜֟֝֜֟֜֟֜֟֜֟֜֟֜֟֜֟֜֟֜֜֟֜֜֟֜֜֓֓֓֓֡֡֡֡֡֡֡֡֡֡֡ | | d | | | | | | | | | | | | |
| be execute sician and unial - tran | | WNPENDED | | | 23a,27, | | ,g924 | 2-2 | 9–12 —— | Sm | | <u> </u> | 2d Data of de | livon | |
| on of Vital Records, P.O. Box 68760, and the Physician: The law requires that the death certificate be that After this certificate has been signed by the attending physician for fineral director, page 2 should be detached for use as the burities of the province of the purification of the physician of the province of the province of the purification of the province of the purification of the province of the purification of | Physician/Me | IF FEMALE: 3b. Was decedent pregnant in | | 3c. If yes, or | utcome of pregi th | | etal death | 3 [| Ectopic | pregnan | ncy | | 3d. Date of de Month | | ay Year |
| th cert | 31018 | past 12 months? 1 Yes 2 No 9 ✔ U | nknown o | = | nt at time of de | ath 5 🗌 C | Other (Spec | cify) | | | | | | | |
| b. BC | Ë | Part II. Other significant cond | | | | esulting in the | underlying | cause g | jiven in Pa | irt I. | | | | | he cause of death? |
| Vital Records, P.O. By vaicins: The law requires that the de his certificate has been signed by the director, page 2 should be detached in the detached of the page 2 should be better the detached of the Day. | 2 | | | | | | | | | | 1 🗌 Ye | es 2 | | | ably 4 🗹 Unknown |
| rds, requir requir | Completed | | | | | | | | | | 24a. Was auto | psy | prid | or to c | opsy findings available ompletion of cause of |
| eco he law ate has | Ē | | | | | | | | | | perf 1 ✓ Yes | ormed 2 | | ath? Ye | s 2 No |
| Entific ctor, p | 2 2 2 | 25. Was case referred to medi examiner? | cal Hosp | ital: | | | | | of Death Other | | | 7 p : | dence 6 | Othor | Scoon |
| of Vital Recoling Physician: The law After this certificate has unreal director, page 2 signal. | <u> </u> | 1 Ves 2 No 27. Manner of Death | | 28a. Date o | npatient 2 | ER/Outpatie | | OOA 28c. Inju | ry at Work | | | | njury occurred | | |
| nd of adding Ph. H.: After t | 힐 | 1 X Notional | ending | (Month, | Day,Year) | | | - | Yes 2 | | | | | | |
| The part of the p | | | | | | ome, farm, str | eet, factory | y, office b | ouilding, et | tc. | 28f. Location or Town, | | | or Ru | ral Route Number, City |
| Div | 1 Natural 5 Pending Investigation 28e. Place of Injury - At home, fa determined (Specify) | | | | | | | | | | | | | _ | |
| | | Check only | Physician: xaminer:On | To the best | t of my knowled of examination a | ige, death occ and/or investig | urred at the gation, in m | e time, da y opinior | ate and pla n, death o | ace, and ccurred a | due to the ca t the time, dat | use(s) te and | and manner a place, and du | is state e to the | ed. e cause(s) |
| To the within To the comp | Medical | 2 Medical E 29b. Signature and title of cert | and | d manner st | ated | | nd/or investigation, in my opinion, death occurred at the time, date and place, a 29c. License number 29d. Date | | | | | d. Date signed | | | |
| | Lyw, s | | | | | | O.C.M.E. February 15, 20 | | | | | , 201 | 2 | | |
| 0 | | 30. Name and address of pers | on who com | pleted caus | se of death (Item | n 23a) | | | | | | | | | |
| 4 | | | | | niner 900 | | ore Stre | et, Bal | timore, | MD 21 | 223 | | | | |
| Sta Registr | | 31. Date filed (Month, Day, Yes | | 32. Re | egistrar's Signat | uie | | | | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1<u>0</u> Month Physician/ ,2012 6:45A Jackson January Ruth Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** <u>Hampstead</u> Carroll Golden Crest Assisted Living 9. Birthplace (State or Foreign Country) South 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Hours Min. **Director** 577-60-6522 1 □ M 2 🛛 F 102 June 24,190þ Carolina Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County notified at Director 1 X Yes 2 No Hampstead Carroll MD 10g. Citizen of What Country? 10e Street and Numbe 10f. Zip Code ö ems 23a or must be r Funeral 4110 Saint Paul 21074 USA Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black "natural", Completed 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 72 al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) Federal Government Clerk traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F 2 Paulin Daisy Brown Moses 1953 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
AVENUE 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st. Department of Health ar Important: If item 27 is any injury or other trau Baltimore, MD 21214 Lynne P. Froe/Niece 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Howard UNIVERS Medical School Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 1/10/12 Washington, DC 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licenses U. 3821 14th Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (ov s a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last and the burial-tra Due to (or as a consequence of) attending physician Physician/Medical certificate be as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Year 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ il or Attending Physician: The law requires after death.

Director: After this certificate has been sign 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed should Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy performed?

1 Yes 2 No death? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 X Other (Assisted Other: 1 ☐ Yes 2 🔀 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending Investigation Accident filled in by the 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar 29b. Signature and title of certifie

Thomas
31. Date filed (Mont

J.

30. Name and address of person w/o completed cause of death (Item 23a) (Type, Print)

MD

Vento

DHMH 17 Rev 06-2011

29c. License number

D62786

114 Business Center Drive, Reisterston, MD 21136

29d. Date signed (Month, Day, Year)

1/10/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State of Maryland / De State State Of Maryland / De State Of Ma | epartment of F Certificate of L | | ientai Hygie _{Reg.} | 2012 | 04621 | | | | |
|----------------------------|--|------------------|--|---|--------------------------------|---|--|--|--|--|--|--|
| ī | Physicia | n/ | 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month January | ^D 27,2012 | 3. Time of Death 12:40A M | | | | |
| | Medio Examin | al | Norma Elizabeth Jordan 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, o | r Location of Death | | 4c. County of Death | | | | | |
| | | | Suburban Hospital | | hesda | | Montgome | | | | | |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Ye | ear) Cour | | | | | |
| - | | | Usual Residence of Decedent | | | July 19 | | SSOUTI 10d. Inside City Limits | | | | |
| | ırylanc 1-f sho ied at | ctor | 10a. State 10b. County 10c. City, Town of | | | | | 1 X Yes 2 No | | | | |
| | the Ma or 28¢ e notif | Dire | MD Prince Georges 10e. Street and Number | Laurel 10f. Zip Code | | 10g | g. Citizen of What Cou | ntry? | | | | |
| | s 23a | Funeral Director | 501 Main Street #406 | 207 | | | USA | | | | | |
| 036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | þ | 11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates. | 13. Was Decedent of H If Yes, specify Cuba1 ☐ Yes 2 X No | | ecify Yes or No- Rican, etc.) | 14. Race - Ameri Black, White, Specify: B1 | | | | | |
| Maryland 21215-0036 | 72 hour r "natu ledical | Completed | (Specify only highest grade completed) (C | lecedent's Usual Occup Give kind of work done of fe. DO NOT use retired) | during most of work | ing 16 | 6b. Kind of Business/Ir | ndustry | | | | |
| 212 | within giene. er thar the M | | Elementary/Secondary (0-12) College (1-4 or 5+) | Secretary | | P | rivate I | ndustry | | | | |
| nd | tal Hyg | To Be | 17. Father's Name (First, Middle, Last) | | 18. Mother's Nam Albert | e (First, Middle, Maid | den Surname) Borlesch | | | | | |
| <u> </u> | d Men marke matic | | James Wesley Pollard 19a. Informant's Name/Relationship (Type, Print) 19b. 1 | Mailing Address (Street | | | | Code) | | | | |
| ⊠ | d 2 sho alth an n 27 is er trau | | Anna Marie Jordan/Daughter 81 | 43 Shoal | Creek L | aurel, l | MD 2072 | | | | | |
| Baltimore, | ge 1 an t of He If item or othe | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State | Disposition (Name of crematory or other plate) | etv | Date 20 | c. Location - City or T | | | | | |
| 탪 | artmen ortant: | | 4X Donation 5 ☐ Other (Specify) Medica 21. Signature of uneral Service Licenses | 1 School | 1/3 | $\frac{0/12}{\text{stip ROV}}$ | ashingto gster Fun | n, DC eral Home | | | | |
| Ba | 21. Signature of uneral Service Licensee 22. Name and Address of Facility Austin ROyster F | | | | | | | | | | | |
| 4) | hysician/ | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on e. o. line. Immediate Cause (Final disease or condition | t enter the mode of dyir | | or respiratory arrest, | | Approximate Interval Between Onset and Death | | | | |
| | Medical Examiner | | resulting in death) Due to (or as a consequence of) | | | l. | | | | | | |
| | | ner | Sequentially list conditions, b. Due to (cross encreage ence of) | | | | | | | | | |
| | outed nd transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events c. | | | | | | | | | |
| _ | cate be executed physician and s the burial-transit | | resulting in death) Last Due to (or as a consequence of) | | | | | | | | | |
| 3760 | ficate I g phys as the | Medical | d | | | | | | | | | |
| . Box 68760 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transition. | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown | 3 | су | | 23d. Date of deli Month | very Day Year | | | | |
| ds, P.O. | quires that the series and signed by ould be deta | by | Part II. Other significant conditions contributing to death but not resulting in | the underlying cause gi | iven in Part I. | | cco use contribute to | the cause of death? | | | | |
| Division of Vital Records, | The law rec cate has be page 2 sho | Completed | | | | 24a. Was an autopsy performe | prior to c ed? death? | opsy findin g s available ompletion of cause of 2 No | | | | |
| lita | sician s certifi | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outp | Oth | Place of Death (Chec | | ce 6 Other (Specia | fv) | | | | |
| on of \ | ending Phy eath. or: After this he funeral o | Certificate: T | 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) inj | ne of 28c. Injui | ry at | 28d. Describe how | | ,,,,,,, | | | | |
| ivisi | l or Atte after de Directo | | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify) | 1, street, factory, office | | 28f. Location (Stree City or Town, S | et and Number or Run State) | al Route Number, | | | | |
| | e Hospita 124 hours e Funeral | Medical | 29a. Certifier (Check (Check only one) 3 ☐ Certifying Physician: To the best of my knowledge, de conly one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge of the conly one) 1 ☐ Certifying Nurse Practitioner: To the best of my knowledge of the conly one) 1 ☐ Certifying Nurse Practitioner: To the best of my knowledge of the conly one) 1 ☐ Certifying Nurse Practitioner: To the best of my knowledge, de conly one) 1 ☐ Certifying Nurse Practitioner: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physician: To the best of my knowledge, de conly one) 1 ☐ Certifying Physi | investigation, in my opini | ion, death occurred a | t the time, date and r | place, and due to the c | ause(s) and manner stated. | | | | |
| | To th withir To th comp | | 29b. Signature and title of certifier | 29c. Licens | | | d. Date signed (Month | Day, Year) | | | | |
| | | | Monas Materson ms | D50 | 534 | | 1/28/12 | | | | | |
| | | | 30. Name and address of person who completed cause of death (Item 23a) (Ty Thomas Masterson MD 6858 O. | ld Domini | on Dr. | #104 McI | Lean, VA | 22101 | | | | |
| | Sta Registr | | 31. Date filed (Month Day, Year) 2012 2. Registrar's Signafure | backer | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 02710/2012 Walter Franklin Joppey Jr 1605 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hosp If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 05/10/1948 Hours Davs 217-46-6758 1 🛂 M 2 🗆 F 63 **Director** MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked of other than "natural", or items 23a or 28a-f show ant: If item 27 is marked of other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Gaithersburg 1 🗆 Yes 2 🔀 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 S Frederick Ave Apt 106 20877 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bus Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Franklin Joppey Sr. Doris Nadine Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4600 Bass Place SE Washington DC 20019 Daughter Lena E. Griggs 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crem 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 02/16/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv meral Service Licen ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? be detached for Month 5 Other (specify) Pregnant at time of death Yes 2 No g Unknown 1 ☐ Yes 2 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an bade 2 autonsv death? certificate ! 1 Yes 2 No I ☐ Yes 2 40 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 filled in by the funeral s after death within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number
00060100 29d. Date signed (Month, Day, Year) 02-10-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Obmina RUD 5. 831 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ rebruary 16, 2012 7:30 A. M Jeanne R. Kramer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Forest Hill Senator Bob Hooper Hospice House 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Hours May 14, 1924 Maryland **Director** 218-14-7401 1 🗆 M 2 🗶 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sl notified 1 Yes 2x No Maryland Wicomico Ocean City 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 21842 United States 615 Harbour Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. White by 1 Never Married 2 Married ☐ Yes 2 XXVIo 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Ith and Mental Hygien
27 is marked other the traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 (Unknown) Frederick Rullman Jennie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Important: If Item 27 is any injury or other trau once. 1303 Henderson Court Bel Air, Maryland 21014 Barbara Nock / Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Feb.Dat 8, 1XXBurial 2 Cremation 3 Removal from State Parkwood Cemetery 2012 Parkville, Maryland 4 ☐ Donatign 5 ☐ Other (Specify) A Funeral Service License Signature Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Dun to for as a nonsecuence of: that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23h Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Hospital or Attending Physician: The Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 은 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29c. License number person who completed cause of death (Item 23a) (Type, Print) DUCAN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | For State Of IV State Registrar | - | Certificate of L | | | Reg. No. | 2 04624 | | | | |
|---------------------|---|-------------------|---|--|--------------------------------------|---|--|--|---|--|--|--|--|
| ı | Physicia | ın/ | 1. Decedent's Name (First, Middle, Last) | | | - | 2. Date of Dea Month | Day Year | 3. Time of Death | | | | |
| | Medio | cal | Leonard Elliott Knis 4a. Facility Name (if not institution, give street and number) | Ley, Sr. | 4b. City. Town, or | Location of Death | Februar | y 15, 2012 4c. County of Dea | | | | | |
| نسب |) LXaiiiii | ici | 924 Martin Road | | Essex | | | Baltim | | | | | |
| | Funeral Director | | 5. Social Security Number 214-90-4989 Usual Residence of Decedent | ge (In yrs. last birthda 49 Yrs | Months Davs | If Under 24 Hrs. Hours Min. | 8. Date of Birtl (Month, Day 11/11/1 | | rthplace (State or Foreign ountry) ryland | | | | |
| | and show | ğ | 10a. State 10b. County | 10c. City, Town or | r Location | | | | 10d. Inside City Limits | | | | |
| | Maryl. 28a-f otifiec | irect | Maryland Baltimore | Essex | | | | | 1 ☐ Yes 2 🔀 No | | | | |
| | ith the 3a or t be n | Funeral Director | 10e. Street and Number 924 Martin Road | | 10f. Zip Code 2122 | 1 | | 10g. Citizen of What C | country? | | | | |
| | ems 2 | une | 11. Marital Status 12. Was Decedent | Ever in U.S. | 13. Was Decedent of H | | ecify Yes or No- | U.S.A. | erican Indian, | | | | |
| Maryland 21215-0036 | is filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show other than "natural", or items 25a or pas-f show event, the Medical Examiner must be notified at | کر ک | 1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🛣 1 ☐ Yes 2 🛣 1 ☐ Yes 2 🛣 1 ☐ Yes Give Year or Dates. | No | If Yes, specify Cuba 1 ☐ Yes 2 🛣 No | | Rican, etc.) | Black, Whi | | | | | |
| 2-0 | 2 hour "natu edical | Completed | 15. Decedent's Education (Specify only highest grade completed) | (G | ecedent's Usual Occup | | king | 16b. Kind of Business | s Industry | | | | |
| 121 | ithin 7 ene. r than the M | Com | Elementary/Seconday (0-12) College (1-4 or | 5+) life | e. DO NOT use retired) Insulator | | | Construct | ion | | | | |
| מ פר | illed w al Hygi I othe vent, | Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nan | ne (First, Middle, i | Maiden Surname) | | | | | |
| ylar | uld be fil Mental narked natic ev | ₽ | Milton B. Knisely | | | Patricia | a Cannon | | | | | | |
| Mar | -1 and 2 should be of Health and Ment fitem 27 is marker rother traumatic e | | 19a. Informant's Name/Relationship (Type, Print) Michelle Knisely (Wife) | T T | Mailing Address (Street a | | | - | | | | | |
| | f Heall item 2 | | 20a. Method of Disposition | 20b. Place of Di | isposition (Name of | | Date Date | 20c. Location - City o | | | | | |
| <u>=</u> | o 5 | | 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 7 | crematory or other place. Crematory | | 20/2012 | Baltimore | Maryland | | | | |
| Baltimore, | permit. Pag Department Important: any injury o | | 21. Signature of Fuck rel Scient Licensee | | 22. Name and Addres | es of Facility ruzdzinsk Eastern <i>A</i> | ci Funera | al Home, P. | A. vland 21221 | | | | |
| ı | | | 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 2122 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shpck, or heart failure. List only one cause on each line. Approximate Interval Between | | | | | | | | | | |
| and . | Physician | | Immediate Cause (Final disease or condition | mary | | Onset and Death | | | | | | | |
| | Medical Examiner | | Due to (or as | a consequence of): | | | 0 | | | | | | |
| | | ner | Sequentially list conditions, If only heading to an include cause. Enter Underlying | е повышения обл | | | | | | | | | |
| 5 | executed an and rial-transit | Examiner | that initiated events c | | | | | | | | | | |
| _ | oe exerician a | | resulting in death) Last Due to (or as | a consequence of): | | | | | | | | | |
| /60 | certificate be executed anding physician and use as the burial-transit | ledic | d | | | | | | | | | | |
| 200 | n certifi ending use a | an/N | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome | | 3 Ectopic pregnance | ·V | | 23d. Date of de | elivery | | | | |
|). Box | the death by the atte ached for | Physician/Medical | | at time of death | 5 Other (specify) | | | Month | Day Year | | | | |
| IS, P.O. | The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as | þ | Part II. Other significant conditions contributing to death | out not resulting in the | he underlying cause giv | ven in Part I. | | bacco use contribute t ⁄es 2 □ No 3 □ F | o the cause of death? Probably 4 Unknown | | | | |
| Records, | aw req as bee 2 shou | Completed | | | | | 24a. Was a | | utopsy findings available completion of cause of | | | | |
| ĕ | The la | Con | | | | | perfor | med? death? | es 2 🖾 No | | | | |
| VItal | sician: certific |) Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: | | Othe | ace of Death (Chec | | | | | | | |
| 010 | g Physer this neral di | e: To | 27. Manner of Death 28a. Date of inj | tient 2 ER/Outpa | e of 28c. Injury | / at | | ence 6 Other (Spe ow injury occurred | cify) | | | | |
| o | eath. or: Aft | ficat | 2 Accident Investigation | ay, Year) inju | | Yes 2 No | | | | | | | |
| DIVISION OF | tal or Att | I Certificate: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injuriding, et | jury - At home, farm, c. <i>(Specify)</i> | , street, factory, office | | 28f. Location (S City or Town | treet and Number or Ri n, State) | ural Route Number, | | | | |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. | Medical | 29a. Certifier (Check 2 Medical Examiner: On the basis of only one) 3 Certifying Physician: To the basis of Certifying Nurse Practioner: To the | examination and/or in | vestigation, in my opinio | on, death occurred a | at the time, date ar | nd place, and due to the | cause(s) and manner stated. | | | | |
| | Withi Com | | 29b. Signature and title of certifier | 0 | 29c. License | number | | 29d. Date signed (Mon | th, Day, Year) | | | | |
| | (| | m Intell Staff | Myrera | V 016 | 7/4 | | 2/10/20 | / _ | | | | |
| | S | | 30. Name and address of person who completed called of MLLHURL FUFFULL JTBV MZ | WAND C. | ACTIONS A | Ve BA | TIMORS | 2 md 21 | 224 | | | | |
| ì | Stat Registra | | 31. Date filed (Month, Day, Year) 32. P 35. | ar's Signature | barker | | . , | | · | | | | |

Please Type or Print in Black Instellible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** owson Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 - M 2 XF 16. 8-29-1924 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified 1 X Yes 2 □ No MD 14 more 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be n 21218 KINK USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, injury or other traumatic event, the Medical Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 0 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black and Mental Hygiene. is marked other than "natural", Completed 3' Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Leader A Team Be 17. Father's Name (First, Middle, Last) 2012 18. Mother's Name (First, Middle, Maiden Surname ည 1450n tattie Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FEBRUARY 12, Department of Health ar Important: If item 27 is any injury or other trau Moorestown, NJ 08057 Cassandra Allen 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 M Burial 2 Cremation 3 Removal from State Timonium, 4 ☐ Donation 5 ☐ Other (Specify) e of Weral Service Licensee MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician CARDIOMYOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the burial-trar attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year signed by the a MARIAM KNOTTS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy performe To the Hospital or Attending Physician: The 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No ည 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔣 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and person who completed cause of death (Item 23a) (Type, Print)

Registrar

JACKIE

JONES,

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Дау Physician/ February 2012 7:49 A. Gladys (nmn) Kolson Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Timonium Social Security Number If Under 6 Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Min 404-20-3419 Director 1 □ M 2 🔀 F 87 Oct. 10, 1924 Kentucky Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No Maryland Harford Bel Air 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral with 21014 801 Moores Mill Road USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. or, à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Logarunent of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magone. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Malcolm (unk) Penix Pearl (unk) Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence F. Kolson / Son 8030 Bradshaw Road, Bradshaw, Maryland 21087 FEBRUARY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \mathbf{X} Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Air Memorial Gdn. 2/20/2012 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. of Funeral Service 50 W. Broadway, Bel Air, Maryland, 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. E her ordening Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician sthe burial Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 🗶 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an Physician: The law has autopsy perform this certificate 1 Yes 2X No 1 Yes 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 👿 No director, **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: in 24 hours and the Funeral Director. After this contained in by the funeral director. ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 1 Yes 2 No 1 X Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🛣 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar

29b. Signature

JACKIE

1. Date filed (Month, Day, Year)

JONES,

CRNP

2300 DULANEY VALLEY RD.

s of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | For State of Marylan | - | artment of Hea tificate of Dea | | | 20 | 112 | 04627 |
|---|------------------|--|---------------------|---|----------------------------|-----------------------------------|----------------------------|---|---|
| | | Registrar 1. Decedent's Name (First, Middle, Last) | Cer | illicate of Dea | 1111 | 2. Date of Dea | | 1 4 | 3. Time of Death |
| Physicia Medic | | Dorothy Kenneally | | | | Month Februa | ry 14,2 | 012 | 1:00P. M |
| Examin | | 4a. Facility Name (if not institution, give street and number) | | 4b. City, Town, or Loca | ation of Death | | 4c. County | | |
| <i></i> | | St. Joseph Hospital 5. Social Security Number 6. Sex 17. Age (In yrs. In | | Tows of | on Jnder 24 Hrs. | | | Balto | |
| Funeral Director | | 220-07-0952 | | | ours Min. | 8. Date of Birtl (Month, Day | ; Year) | Country | |
| MC 1 | | Usual Residence of Decedent 92 | | | | May 26, | 1919 | | yland |
| iryland I-f she ied at | ctor | | y, Town or Loc | | | | | 100 | d. Inside City Limits 1 ☐ Yes 2 💢 No |
| he Ma or 28a notif | Dire | Md. Balto. Basto. 10c time Englishment Basto. Bas | | Timonium 10f. Zip Code | m | 1 | 10g. Citizen of \ | What Countr | |
| with t | Funeral Director | 2300 Dulaney Valley Road | | 21293 | | | | SA | , · |
| min der | اڇ | 11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates. | If | Vas Decedent of Hispan Yes, specify Cuban, Me ☐ Yes 2 X No Sp | exican, Puerto I | cify Yes or No- Rican, etc.) | | e - Americar ck, White, et | |
| 2 hou "natu | plet | 15. Decedent's Education (Specify only highest grade completed) | (Give k | ent's Usual Occupation ind of work done during | | ng | 16b. Kind of B | usiness/Indu | stry |
| ithin 7 | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) | _ | NOT use retired) | | | Federal | Gove | rnment |
| filed w filed w other vent, i | a B | 17. Father's Name (First, Middle, Last) | 560 | | Mother's Name | e (First, Middle, I | | | |
| ylar | 욘 | William F. Hartman | | | Margar | et B.Mc | Neill | | |
| Maryland d 2 should be filed alth and Mental Hy 127 is marked oth | 1 | 19a. Informant's Name/Relationship (Type, Print) Patricia Stipek Sister | 19b. Mailin | g Address (Street and N Sandyvale | lumber or Rura Road | l Route Number, Kingsvi | City or Town, S 11e, Md | tate, Zip Co • 210 | ^{de)} 87 |
| altimore, rmit. Page 1 and partment of Hea portant: If item y injury or othe | | 1 😾 Burial 2 □ Cremation 3 □ Removal from State | emetery, crem | sition (Name of attory or other place) | | Date | 20c. Location - | - | |
| Iltim artmer ortant injury | ŀ | 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee | Josep | Name and Address of I | | -2012 | Fuller Funeral | | |
| Bal permit Depar Impor any in | | Busall | | 9705 Belai | r Road | Nottin | gham,Md | . 212 | 36 |
| medical physician and sthe burial-transit sthe burial-transit | Examiner | 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) of the conditions of the con | ence of): | | | | | | Approximate niterval Between Interval Between Inget and Death |
| BOX 68 death certifi te attending ed for use a | Physician/ | d | I death 3 eath 5 | Other (specify) | Part I. | 23e. Did to | Мо | | ay Year |
| uires t uires t uid be | ed by | | | W | | 1 □ Y | es 2□No | 3 Proba | bly 4 Miknown |
| Hec(The law ate has page 2 | Completed | | | | | 24a. Was a autop: perfor 1 Yes | med? | Were autops prior to comp death? 1 \(\sum \) Yes 2 | y findings available pletion of cause of |
| Ital sician certifi irector | m , | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Input and 1 | | Other | f Death (Check | | | | |
| of V g Phys er this eral d | e: To | 27. Manner of Death 28a. Date of injury | 28b. Time of | 28c. Injury at | | me 5 🗌 Reside 28d. Describe ho | | | |
| on on ending sath. | ficat | 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation | injury | M 1 ☐ Yes | 2 🗆 No | | | | |
| DIVISION OF tal or Attending PP s after death. I Director. After th ed in by the funeral | Certificate: | 3 ☐ Suicide 4 ☐ Homicide determined 28e. Place of Injury - At ho building, etc. (Specify, | | et, factory, office | 1 | 28f. Location (St City or Town | | er or Rural R | oute Number, |
| Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Medical (| 29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination | edge, death o | ccurred at the time, date | e and place, an | d due to the car | use(s) and mann | er as stated | e(s) and manner stated |
| o the lithin 2 o the loomple | | only one) 3 Certifying Nurse Practitioner: To the best of m | y knowledge, | death occurred at the tim | ne, date and pla | ce, and due to th | e cause(s) and m | nanner as sta | ted. |
| FSFÖ | | Par J. Ma- | | 0328 | ن حو د | | 2/1 | 1/20 | 12 |
| 6 | | 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 31. Date filed (Month, Day, Year) 22. Registrar's Signat | 23a) (Type, Pi | rint) | D | . P. | | fare | MX 3117 |
| State Registra | Ç | 31. Date filed (Month, Day, Year) FEB 1 7 2012 | bar | W | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2&29d Per PHY G924-2/17/2012 The State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 Josephine M. Kayse 5:01 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Director 212-40-2707 1 M 2X F 76 06/13/1935 Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No Maryland | Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KAYSE, DOSEPHINE Baltimore, Maryland 21215-0036 Funeral 1241 St. Andrews Lane 21113 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. ral", or iten Examiner r 14. Race - American Indian. Armed Forces Black, White, etc 1 Never Married 2 X Married Completed by Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Retail Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rudolph Urban Mabel Pumphrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James Kayse/Husband 1241 St. Andrews Lane, Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Qonation 5 Other (Specify) Glen Haven Memorial Park 2/11/12 Glen Burnie, Maryland 21. Signat 22. Name and Address of Facility Kirkley-Ruddick Funeral Home Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card SE, Glen Burnie, Maryland 21061 Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician an disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transi Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month pau the 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No Yes within 24 hours after deau..

To the Funeral Director. After this certification and set of the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes Other: ၉ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Inpatient 2 27 Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 07 ress of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2 Medical 4a. Facility Name of not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1747 Covington Street N/ABaltimore Social Security Number 215–28–4815 6. Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Min Director 1 🖾 M 2 🗆 F 79 8/28/32 OH 28a-f show "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore City 1 X Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10a, Citizen of What Country? 1747 Covington Street Funeral 21230 USA filed within 72 hours after death v al Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

**XX*Yes 2 \sum No Armed Fyes, Give \$53-5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Army 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 53-55 White Specify: Completed 3 Widowed 4 Divorced Year or Dates item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pipefitter Chemical Company Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph H. King Grace Boggs should be . Page 1 and 2 should ment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1747 Covington Street, Baltimore MD 21230 King / Virginia M. Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Glen Haven Cemetery ō XX Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 2/10/2012 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat (e of Formal Service Licensee Victor P. Doda 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Inset and Death Mesotheliama Physician disease or condition resulting in death) 0 MUS Medical Due to (or as a consequence of): Examiner 10 Urs its bestosis Esquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death signed by the a 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After the funeral 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in by Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Keney Dew February Le, りろりんし 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buit

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month

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| | | | For State of N | 1aryland | - | artment of H | | Mental Hyg | jiene | 12 01.626 |
|----------------------------|--|--------------------------|--|---------------------------------|----------------------------|--|--------------------------------|-----------------------------------|-------------------------|---|
| _ | | | Registrar 1. Decedent's Name (First, Middle, Last) | | Cer | tificate of D | eath | 2. Date of Dea | leg. No. 🚄 👢 | 112 04030 |
| | Physicia | | Robert J. | Kals | k i | | | Month Februa | D | 3. Time of Death 2012 2:56p M |
| | Medio Examin | | 4a. Facility Name (if not institution, give street and number) | Raib | 10.1 | 4b. City, Town, or | Location of Death | | 4c. County | |
| 700 C | <u> </u> | | Anne Arundel Medical | | | | apolis | | | e Arundel Co. |
| × | Funeral Director | | 5. Social Security Number 213-32-8570 6. Sex 17. A | ge (In yrs. lasi | t birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | Year) | Birthplace (State or Foreign Country) |
| | | | Usual Residence of Decedent | 7. | 5 Yrs. | | | 7-24-1 | 936 | Maryland |
| | /land f sho | tor | 10a. State 10b. County | - | Town or Loc | | | | | 10d. Inside City Limits |
| | e Mar r 28a- notifie | Director | MD Anne Arundel 10e. Street and Number | Lage | wate | 10f. Zip Code | | | | 1 ☐ Yes 2 🖾 No |
| | vith th | | 1130 Paca Drive | | | 21037 | 7 | | 10g. Citizen of \ US | • |
| | filed within 72 hours after death with the Maryland tal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Funeral | 11 Marital Status 12, Was Decedent | Ever in U.S. | 13. V | Vas Decedent of His | spanic Origin? (Sp | ecify Yes or No- | 14. Rac | e - American Indian, |
| 36 | ifter d ", or i | by | Armed Forces 1 Never Married 2 Married Armed Forces 1 Yes 2 If Yes, Give | No | | Yes, specify Cuban | | Rican, etc.) | | ck, White, etc. :White |
| Ş | ours a atural | Completed | 3 Widowed 4 Divorced Year or Dates. | | | ent's Usual Occupa | | | | |
| 215 | n 72 h an "na Media | ldu | (Specify only highest grade completed) | | (Give k | rind of work done du NOT use retired) | uning most of work | king | 160. KING OF B | usiness/Industry |
| 21 | l withii /giene ner th t, the | | $\begin{array}{c c} \text{Elementary/Secondary (0-12)} & \text{College (1-4 or N/A)} \\ 12 & \text{N/A} \end{array}$ | 31) | Admi | nistrato | or | | U.S. | Military |
| and | be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at | To Be | 17. Father's Name (First, Middle, Last) Frank Kalski | | | | 18. Mother's Nam | ne (First, Middle, M e Aluza | | e) |
| Maryland 21215-0036 | ould d Me mar mati | Ï | 19a. Informant's Name/Relationship (Type, Print) | - 1 | 19b Mailin | g Address (Street ar | | | | State Zip Code) |
| | S is | - 3 | Mildred Kalski - Wife | 1 | | Paca Dr | | | | |
| Baltimore, | of Heal | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State | | ce of Dispo | sition (Name of natory or other place |) 2 1 | Date 7 - 2012 | 20c. Location - | - City or Town, State |
| Ĭ | t. Page tment o tant: If ijury or | | 4 Donation 5 Other (Specify) | St. | | nislaus | Cem. | | | ltimore, MD |
| Ra | permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti | Q S | 21. Signature of Eureral Service Licensee | 01259 | | | | | | neral Home,PA re,MD 21222 |
| | | | 23a. Part 1. Enter the disease, or complications that caus- shock, or heart failure. List only one cause on each li | ed the diath. | Do not ente | r the mode of dying | , such as cardiac | or respiratory arre | est, | Approximate Interval Between |
| | Physician/ Medical | | Immediate Cause (Final disease or condition resulting in death) | 11/2 | FUL | r He | MELL | have | | Onset and Death |
| - | Examiner | | Due to (or as | a con equer | nce of): | S W | | J | | |
| | | ner | Sequentially list conditions, if any, reading to immediate cause. Enter Underlying | a conseque | rescip | | | | | |
| | executed an and rial-transit | Examiner | Cause (Disease or injury that initiated events c. | | | | | | | |
| | be exec sician a | | resulting in death) Last Due to (or as | a consequer | nce of): | | | | | |
| /60 | physic | edical | d | | | | | | | |
| 200 | requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit | Completed by Physician/M | IF FEMALE: 23c. If yes, outcom | | | 1 Fatania maranana | | | 23d. Da | te of delivery |
| ROX | death ne atter | sicis | 1 Yes 2 No 4 Pregnant | at time of dea | | Ectopic pregnancy Other (specify) | | | Mo | onth Day Year |
| л Э | at the d by th | Phy | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death | | ting in the u | nderlying cause give | en in Part I. | 23e Did tol | pacco use cont | ribute to the cause of death? |
| | law requires that the has been signed by the e.2 should be detach | d by | | | 5 | , , | | 1 □ Y | -/ | 3 Probably 4 Unknown |
| ord | v requ | lete | | | | | | 24a. Was a | | Were autopsy findings available |
| Zec Zec | sician: The law i certificate has b lirector, page 2 s | omi | | | | | | autops perfor | med? | prior to completion of cause of death? 1 ☐ Yes 2 ☐ No |
| <u></u> | clan: ertifica ector, | Be (| 25. Was case referred to medical examiner? | | | | ce of Death (Chec | | | |
| > | Physi this o | : To | 1 Yes 2 | tient 2 EF | R/Outpatien 8b. Time of | | 4 LI Nursing He | ome 5 Reside | | |
| 0 | th. After | cate | 1 Natural 5 Pending (Month, D | ay, Year) | injury | 28c. Injury work? M 1 🗆 N | /es 2 □ No | 28d. Describe ho | w injury occurr | ed |
| Division of Vital Records, | er dea rector by th | Certificate: | 3 Suicide 6 Could not be 28e. Place of Ir | jury - At hom- tc. (Specify) | e, farm, stre | et, factory, office | | 28f. Location (St City or Town | | er or Rural Route Number, |
| 2 | oital or urs aft ral Dir | | | | | | | | | |
| | To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Medical | 29a. Certifier (Check 2 Medical Examiner; On the basis of only one) 3 Certifying Nurse Practitioner: To the same of the basis of only one) Certifying Nurse Practitioner: To the basis of t | examination a | ind/or invest | igation, in my opinior | n, death occurred a | it the time, date an | d place, and due | e to the cause(s) and manner stated |
| | To the within To the Compl | Σ | only one) 3 L Certifying Nurse Practitioner: To the 29b. Signature and title of certifier | ne best of my | Kilowiedge, | 29c. License | | | | d (Month, Day, Year) |
| | | | N/ / / / / | m | 7 | 000 | 38 44 | 5 | 02/1. | 2/2012 |
| 4 | | | 30. Name and address of person who completed cause of | death (Item 2 | 3a) (Type, P | rint) M | 1 1 | | , A. | anditi ma |
| | Stat | | 31. Date filed (Month, Day, Year) 32. Poisi | ar's Signatur | 1 | 1 1/0/11 | h NO | MINNEY | , // | ערון כון טקאיוי |
| | Registra | ar | FEB 1 7 2012 | un p | 7. 1 | arke | | | | |

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|-------|---|--|------|---|-----|---|---|--|
| Frame | ~ | | Feet | | . 6 | | - | |

| olali Latillou | 1 | - For State | tate of Mary | Cei | tificate of | Death | | | R | Reg. No. | 21 | |) 400 |
|--|---------------|---|---|-----------------------------------|--------------------------------------|--|--|--------------------------|-------------------|---------------------|--|--------------------------------|----------------------|
| Physicia | | Registrar 1. Decedent's Name (First, Midd | ile,Last) | | | | | | Date of Dea | | Year | 3. Time of D | 1 |
| al Examir | | Deborah | Lathr | oum | | | | | Month February | | | 0910 h | rs |
| | | 4a. Facility Name (if not institution | on, give street and n | umber) | | 4b. City, Town, or | Location of | Death | | 4c. 0 | County of D | | |
| | | Johns Hopkins Bayvi | ew Medical Cer | iter | | Baltimore | | | | | | N/A | |
| Funeral | 7 | 5. Social Security Number | 6. Sex | 7. Age (In yrs. I | ast birthday) | If Under 1 Yea | | 24Hrs. Min. | 8. Date of B | irth(MM/DI | D/YYYY) 9 | 3. Birthplace (State oreign | e or |
| Director | | 441-66-9782 | 1 M 2 F | | 52 Yrs | Months Day | S Hours | IVIII I. | 04/2 | 6/195 | 9 | Country) MI | |
| | ŀ | Usual Residence of Decedent | | | | | | | | | | 10d. Inside | City Limits |
| ku w | ţ | 10a. State 10b. County | , | 10c. City | , Town or Local | ion | | | | | | 1 Yes | · |
| | _ | Maryland Bal | timore | | | Ba | altimo | ore_ | | | | | - X |
| Maryland 28a-f show d at once. | 윉 | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citize | en of What | Country? | |
| nith the Maryland 123a or 28a-f show 2 notified at once. | Director | 301 Gusryan S | Street. | | | | 21224 | 1 | | | | USA | |
| with t | | 11. Marital Status | 12. Was De | ecedent Ever in U | J.S. 13. W | as Decedent of Hi /es, specify Cuba | spanic Origi | in? (Spec | cify Yes or N | lo- 1 | Race - A White, e | American Indian, E etc. | Black, |
| eath v | Funeral | 1 Never Married 2 | Married Armed | Forces? | n i | res, specify Cuba | i, i i i i i i i i i i i i i i i i i i | , doi:to | , , , , , , , , | | Specify: V | White | |
| fter d | | 3 Widowed 4 D | ivorced If Yes, Give Y | ear X | 1 | Yes 2 X No | | | | | | | |
| ours a | Completed by | 15. Decedent's Education (Sp | ecify only highest gr | ade completed) | 16a. Decede | nt's Usual Occupa | ation (Give k e. DO NOT u | kind of wo use retire | ork done ed) | 16D. KI | na or Busir | ness/Industry | |
| 72 hc | 용 | Elementary/Secondary (0-12 | 2) College | (1-4 or 5+) | | | | | | | | 1 7 7 | |
| O36 ithin | 립 | 11 | | | <u></u> | Homema | ker | e Name (| First, Middle | Maiden S | HOL Surname) | usehold | |
| 5-0036 led within 7 Hygiene. I other than | | 17. Father's Name (First, Middl | | | | | | | | Houck | | | |
| 2121 suld be fi marked ic event, | B | John Mor | | | 19h Mailir | ng Address (Stre | et and Num | irley | ral Route N | umber, Cit | y or Town, | State, Zip Code) | |
| ID 21215-003 should be filed within and Mental Hygiene. 17 is marked other the matic event, the Med | 7 | 19a. Informant's Name/Relation | | | 1 | | | | | | | | |
| b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland (eath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once | | William Dale 20a. Method of Disposition | Moran (| son) | . Place of Dispo | 3 Hog Ne sition (Name of c | CK ROa emetery, | | Date | 20c. L | ocation - C | City or Town, State | |
| Baltimore, MD 21215-0036 pepenit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. In portant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. | | 1 Burial 2 Cremati | ion 3 Removal | from State | crematory or o | ther place) | | Feb | | | 11. | Ma ama | 1 500 |
| Pages 1 nent of H ant: If it | | 4 Donation 5 Other | Specify: | M | | ematory Name and Addre | | | 2012 | | | <u>re, Mary</u> al Home, | |
| Salt rmit. epartu nporti jury | | 21. Signature of Funeral Service | ce dicensee | 11. | 1) 2 | | | | | | | MD 21122 | |
| | | 23a (Part I. Enter the disease, | or complications tha | caused the deal | Do not enter | the mode of dyin | g, such as ca | ardiac or | respiratory | arrest, sho | ck, or hear | t Approxim | nate Interval |
| Physician /Medical | | failure. List only one cau | se ou each line. | | | | | | | | | Between | n Onset and Death |
| ≟xaminer | | Immediate Cause (Final disea or condition resulting in death | | lone Int s a consequence | | on | | | | | | | |
| | | | b. | o a control que ne | | | | | | | | | |
| | e | Sequentially list conditions, if any, leading to immediate | | s a consequence | of): | | | | | | | | |
| | miner | cause. Enter Underlying Cau- (Disease or injury that initiated | d C | s a consequence | of): | | | | | | | _ | |
| cuted und transit | X | events resulting in death) Las | st Due to (or a | a consequence | . 0. j. | | | | | | | | |
| xecut n and I - trai | Medical | X UNPENDED | | D 23a,27 | ,28a-f, | per me,g | 924 2- | -22-1 | 12 sm | | | 1 | |
| 60, ate be exe thysician | <u>6</u> | IF FEMALE: | 23c If ve | es, outcome of pr | egnancy | | | | | 230 | d. Date of c | - | |
| 876 ificat ng ph | 3 | 23b. Was decedent pregnant in past 12 months? | | e birth | | Fetal death | 3 Ectopi | ic pregna | ncy | i | Month | Day | Year |
| Box 687, death certificate at the attending ped for use as the | Si | 1 Yes 2 No 9 | 171 | egnant at time of | death 5 | Other (Specify) | | | | | | | |
| D. Box 687(that the death certifica ned by the attending pl detached for use as the | Physician/ | Part II. Other significant con | 1 2 0 | known | t reculting in th | e underlying caus | e given in P | art I. | 23e. Di | id tobacco | use contril | bute to the cause | of death? |
| ires that the signed by t | Ş P | | iditions contributin | g to death but he | n resulting in th | o andonying occu- | 9 | | 1 🗆 | Yes 2 | / No 3[| Probably 4 | Unknown |
| By P | | | | | | | | | 24a. W | las an | 24b. V | Vere autopsy findi | ngs available |
| cords, law requir has been s | 1 1 | | | | | | | | | utopsy erformed? | | nor to completion leath? | |
| Recc The lav icate har | Completed | | | | | | | | 1 🗸 Y | es 2 N | No 1 | ✓ Yes | 2 No |
| of Vital Records, ag Physician: The law require the true rectificate has been similar this certificate has been similar director, page 2 should be | B B | | | | | | Other ₄ | | | | | Other: | |
| Vital I hysician: | 8 | 1 ✓ Yes 2 No | Hospital: 1 | | ✓ ER/Outpati | | | | ng Home 5 | | ence 6 _ jury occurre | | |
| Of ing Ph | - | . 127 Manner of Death | (M | ate of Injury onth, Day, Year) | 28b. Time | | njury at Wor | _ | unkn | | july occurr | 24 | |
| On cath. | 1 5 | 1 Natural 5 F | dimediam | 2-14-12 | | | | | | | and Numb | er or Rural Route | Number City |
| Division Lal or Attendi rs after death. Tal Director: A | 1 12 | 3 Suicide 6 XX | Could not be 28e. | | | treet, factory, office | ce building, 6 | etc. | _ or_Tow | vn, State) | 301 G | Susryan S | St. |
| Divisior ospital or Attend hours after death aneral Director: | Certification | 4 Homicide | determined (Spe | | sidence | | | | | imore | | as stated | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Purezan Director: After this certificate has been signed by the attending physician and commented filled in white fineral director, page 2 should be detached for use as the build—transity comments. | 7 | | g Physician: To the Examiner:On the ba | best of my know | rledge, death or on and/or invest | courred at the time igation, in my opin | e, date and p nion, death c | olace, and occurred | at the time, | date and p | lace, and c | lue to the cause(s | ;) |
| To the vithin To the Count | Modical | one) 2 Medical | , and man | ner stated. | 16 | | ense numbe | | | | | ed (Month, Day, Y | |
| | 2 | 29b Signature and title of ce | 140)/ | 1/20 | 80 | | C.M.E. | | | Fe | bruary 1 | 5, 2012 | |
| | | Outer fla | lle Ve | ese 1 | | | | | | | | | |
| | | 30. Name and address of pe | | cause of death (Medical Exa | ltem 23a) miner ຊດເ |) W. Baltimor | e Street. | Baltimo | ore, MD 2 | 1223 | | | |
| | | Victor Weedn MD | | Registrar's Sig | nature • | | | | | | | | |
| Reg | Stat istra | | 2012 | ARAMA A | 1. ba | Mal | | | | | | | |
| | | | | | ORIGI | NAL | | | | | | | |
| DHMH 17 Rev | 11200 | 1 | OCME | | 0,40 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Rose Coleman Lansdowne Physician/ February 2012 11:57a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3422 MONDAWMIN AVENUE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Days Months Min (Month, Day, Year) **Director** 214-22-5125 1 M 2 X F 90 Yrs 05/26/1921 VIRGINIA Usual Residence of Deced ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3422 MONDAWMIN AVENUE 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. o, þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give nours after 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-003 permit. Page 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygfene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa Completed 3 X Widowed 4 Divorced Year or Dates BLACK 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th TELEPHONE LINE OPERATOR WESTERN ELECTRIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LAFAYETTE COLEMAN FANNIE MADISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSLYN L. MCPHEARSON/DAUGHTER 3422 MONDAWMIN AVE. BALTIMORE, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Domation 5 Other (Specify) 02/17/2012 ARBUTUS MEM. PARK BALTIMORE, MD re of Funeral Service Lice WILLIAM Address BROWN COMMUNITY FUNERAL HOME P.A. May 1206 W. NORTH AVE. BALTIMORE, MD 21217 art 1. Enter the disease, or co ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List o one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) uloca Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy perform After this certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check **Gertifying Nurse Practitioner** Digitis Seat of my knowledge, 3 act. Securing at the time, date and place, and due to the caucally and manner as stated 29b. Signature and title of certifier 29c. License number MIC 16666 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #11 Registrar

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State of Maryland / Department of Health and Mental Hygiene

| | | | For State Registrar | Oldio of Mid | ii yiai ia / i | | ficate of L | | arra iv | , | Reg. N | 2012 | 04 | 633 |
|----------|---|-------------------------|---|---|-----------------------|-------------------------------|---|------------------------------|-----------------|--|---------|---|---|-----------------------|
| | Physicia | n/ | Decedent's Name (First, Middle, L. | · | | | | ~= | | Date of Dea Month | | ay 13 2012 | 3. Time of | |
| | Medic | al | FRED 4a. Facility Name (if not institution, gir | W. | | | KHART 4b. City, Town, or | JR. | of Death | FEBRUA | | 13 2012 c. County of Deatl | 6:48 | P M |
| | Examin | er | 547 TRANQUIL C | | | | ODENTO | | Ji Dodan | | | NNE ARUN | | |
| Ì | Funeral Director | | 5. Social Security Number 6. 237–80–5323 | Sex 7. Age 1 X M 2 D F 6 | (In yrs. last birt | | If Under 1 Year Months Days | If Under Hours | 24 Hrs. Min. | 8. Date of Birt (Month, Day MAY 29 | h | g. Birt | hplace (State of | or Foreign |
| | | | Usual Residence of Decedent | | | | | | | MAI 29 | 17 | 40 INUK | | |
| | aryland a-f sho fied at | Funeral Director | 10a. State 10b. County | | 10c. City, Tow | | tion | | | | | | 10d. Inside Ci | ity Limits |
| | or 28 | Dir | MD ANNE AI 10e. Street and Number | RUNDEL [| ODEN | TON | 10f. Zip Code | | | | 10g. C | itizen of What Co | Λ_ | |
| | n with | nera | 547 TRANQUIL COL | URT APT D | | | 21113 | | | | USA | A | | |
| 2-003p | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by | 11. Marital Status 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates. | | | s Decedent of Hi res, specify Cuba ☐ Yes 2 XNo | | | cify Yes or No- Rican, etc.) | | 14. Race - Amer Black, White Specify: B | | |
| -C | 72 hou n "natu 1edical | Completed | 15. Decedent's (Specify only highest) | grade completed) | | (Give kin | nt's Usual Occup ed of work done o NOT use retired) | ation <i>Juring m</i> ost | t of workii | ng | 16b. l | Kind of Business I | ndustry | |
| 717 | within giene. er thau | | Elementary/Seconday (0-12) | College (1-4 or 5+ | -) | | CK DRIVE | ER | | | GO | OVERNMEN' | [| |
| yland | e filed tral Hy ed oth event | To Be | 17. Father's Name (First, Middle, Last | • | | | | | | (First, Middle, | | | | / |
| | should be file and Mental is marked of aumatic eve | | FRED W. LOCKHAI 19a. Informant's Name/Relationship | | 194 | Mailing | Address (Street | | SEPH] | | PERI | KY r Town, State, Zip | Codel | |
| , Mal | nd 2 sh ealth ar m 27 is ier trau | 83 | LAVERNE LOCKHART | | | | | | | | | N, MARYLAI | | .3 |
| nore | age 1 au int of Hi t: If item / or oth | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | Removal from State | cemete | ry, crema | ion (Name of tory or other place | | | Date | | ocation - City or | | TD. |
| baltimol | permit. Page 1 Department of Important: If ii any injury or o | | 4 ☐ Donation 5 ☐ Other (Spe- 21. Signature of Funeral Service Lice | | KIVEK | _ | CREMATO | | | | | /ERDALE,1 NS FUNER | | |
| ñ | | 13 | ► Waphney 1 | V. Cornel | MA | | | | | | | LE,MARYL | AND 207 | 785 |
| | hysician/ | | 23a. Part 1, Enter the disease or co- shock, or heart failure. List only Immediate Cause (Final | mplications that caused to one cause on each line. | the death. Do r | not enter t | the mode of dying | g, such as | cardiac o | r respiratory an | est, | | Approximat Interval Bet Onset and | ween |
| | Medical Examiner | | disease or condition resulting in death) | a. CARCTNO Due to (or as a | | | | | _ | | | 1 | | |
| | Exammer | er | Sequentially list conditions, if any, leading to immediate cause. Enter Inderlyin | b. Due to (or as a | consequence | of). | | | | | | | | |
| | uted Id ansit | amir | Cause Enter Underlying Cause (Disease or iinjury that initiated events | C | | | | | | | | | | |
| | oe exec ician ar burial-ti | Medical Examiner | resulting in death) Last | Due to (or as a | consequence | of): | | | | | | | | |
| 20/20 | icate by physics the | l edic | | d | | | | - | | | | | | |
| DOX OC | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown | Petal deat | h 3 🗆 6 | Ectopic pregnanc Other (specify) | у | | | Į. | 23d. Date of deli Month | - | Year |
| Γ. Ο | that th | by Ph | Part II. Other significant conditions | contributing to death bu | t not resulting | in the unc | derlying cause giv | en in Part | 1. | 23e. Did to | bacco | use contribute to | the cause of d | leath? |
| ds, | equires een sign ould be | | | | | | | | | 1 🛣 | Yes 2 | !□No 3□Pr | obably 4 🗌 | Unknown |
| Records, | The law re cate has be page 2 sh | Completed | | | | | | | | | | death? | opsy findings ompletion of c | available cause of |
| N I G | sician: certific | Be C | 25. Was case referred to medical examiner? 1 ☐ Yes 2 【 No | Hospital: | | | Othe | ace of Deater: | | | | _ | | - |
| 5 | ig Physical dispersal di | te: To | 27. Manner of Death | 1 ∐ Inpatier 28a. Date of injury (Month, Day, | nt 2 ER/Ou / 28b. | Itpatient Time of njury | 3 LJ DOA 28c. Injury work | 4 ∐ Nu ⁄at | | me 54 Resid 28d. Describe h | | 6 Other (Speci ry occurred | fy) | |
| 000 | ttendir death. tor; Af the ful | Certificate: | 1 Natural 5 ☐ Pending 2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not | ion | | | M 1 🗆 | Yes 2 🗆 | _ | | | | | |
| DIVISION | tal or Atres as after and Directed in by | | 4 Homicide determine | 28e. Place of Injur building, etc. | | irm, stree | т, тастогу, опісе | | | 28f. Location (S City or Tow | | nd Number or Rur e) | al Houte Numb | oer, |
| | Hospi 24 hou Funer eted fill | Medical | (Check 2 Medical Exa | hysician: To the best of m miner: On the basis of exa urse Practioner: To the b | amination and/o | or investig | ation, in my opinic | n, death oc | ccurred at | the time, date a | nd plac | e, and due to the c | ause(s) and ma | anner stated. |
| | To the within To the compl | Σ | only one) 3 Certifying No. 29b. Signature and title of certifier | arse Practioner, to the b | ost of fly know | leage, aea | 29c. License | | anu piaci | - | | ate signed (Month | | |
| | mo | | Rech | had be | -4 | | | 9357 | | | FE | BRUARY 1 | 4, 2012 | 2 |
| _ | 20, | | 30. Name and address of person who RICHARD LILY 1 | | | | | TSVI | LLE, | MARYLA | ND 2 | 20781 | | |
| | Stat Registra | | 31. Data filed (Month, Day, Year) | 32. Registrar | 's Signature | 1 | | _ | | | | | | |

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AMEND ITEM#17perFH,G924,2/24/2012,WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical WCA M OL IFEN 4a. Faculty Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days 230-32-5562 Director 1 M 2 XF 84 3-18-1927 VA Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified 28a-f Yes 2 ☐ No n/a Baltimore 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? 23a 3114 Oakfield Avenue 21216 USA ral", or items ? Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Completed by 1 Never Married 2 X Married should be filed within 72 hours after 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African-American 3 Widowed 4 Divorced Year or Dates item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) 6th Baltimore City Public School Cafeteria Aide Be Father's Name (First, Middle, Last)
Thomas William Jefferson
William Jefferson 18. Mother's Name (First, Middle, Maiden Surname) ပ Lula Paige Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl L . Leftwich/Granddaughter 9003 Bruno Road, Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Date Department of Important: If it any injury or o 2-24-2012 Donation 5 Other (Specify) Garrison Forest Veterans Owings Mills, MD 22. Name and Address of Facility Wile Funeral Home P.A. of Baltimore Co. 21. Signature of Funeral Service Licens 9200 Liberty Road, Randallstown, MD 21133 Fift 1. Ent if the 1 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month 9 Unknow P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: **₹**DNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence completely filled in by the funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 7 6 Day, Year 2012 32. Registrar's Signature State 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For | State of M | arylar | | | | | lental Hy | giene | | |
|-------------------|---|--------------|---|--|---------------------------|------------------|--|-------------------------|------------------------------|----------------------------------|--------------------------------------|--------------------------------------|--|
| | | | State Registrar | | | Cer | tificate of | Death | | | Reg. No. 🤈 [| 112 | 04635 |
| П | Physicia | an/ | 1. Decedent's Name (First, Middle, La | nst) | | 1 = | | _ | | 2. Date of Dea | ath Pay - | Year | 3. Time of Death |
| · | Medic Examir | | 4a. Facility Name (if not institution, giv | e street and number) | | L- C | 4b. City, Town, o | | a of Dank | TEB | 1220 | 12 | 6-77 M |
| لريب | / Examin | ler | 8620 SILVER KNO | | | | 4b. City, lowii, c | | RRY H | АТТ | 4c. County | | BALTO. |
| | Funeral | Г | | | je (In yrs. I | ast birthday) | If Under 1 Year | If Unde | er 24 Hrs. | 8. Date of Birt | | 9. Birth | place (State or Foreign |
| Ь | Director | | | 1 🗙 M 2 □ F | 59 | Yrs. | Months Days | Hours | Min. | (Month, Day | | VIR(| GINIA |
| | nd thow | 5 | Usual Residence of Decedent 10a. State 10b. County | | 10c. Cit | y, Town or Lo | ation | | | | | 1 | 10d. Inside City Limits |
| | faryla 8a-f s tified | Director | MD BAL | го. | | PERF | Y HALL | | | | | | 1 ☐ Yes 2 🔀 No |
| | a or 2 | | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citizen of | What Cour | ntry? |
| | h with | Funeral | 8620 SILVER KNO | LL DRIVE | | | 2112 | 28 | | | USA | | |
| | r iten | | 11. Marital Status | 12. Was Decedent Armed Forces? | | | Vas Decedent of I Yes, specify Cub | Hispanic C an, Mexic | rigin? (Spec an, Puerto F | cify Yes or No- Rican, etc.) | | e - Americ | |
| 336 | s after al", o Exam | d by | 1 ☐ Never Married 2x Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 If Yes, Give Year or Dates. | No | 1070 | ☐ Yes 2x No | Specif | fy: | | Specify | | |
| 21215-0036 | within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at | Completed | 15. Decedent's | Education | 19/0- | 16a. Deced | ent's Usual Occu | pation | | | 16b. Kind of B | usiness/Inc | dustry |
| 21 | nin 72 be. than " | E O | (Specify only highest g | College (1-4 or | 5+) | life. Do | ind of work done ONOT use retired |) | ost of workir | ng | | | |
| | d with hygier ther t | ادها | 12 TH | · · · · · | | FIRE | FIGHTER | | | | BALTO. | | NTY |
| Maryland | ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | To B | 17. Father's Name (First, Middle, Last) CHARLES D. WALLA(| | | | | Ì | | | Maiden Surnam | e) | |
| ary | should and Me rsumati | | 19a. Informant's Name/Relationship (| | | 19h Mailin | g Address (Street | | | MCDANIE | | State Zin (| Cadel |
| | d 2 sh alth a 1 27 is er trau | | DIANE LEGGE | SPO | USE | I SS, Wallin | 8620 SI | | | | | | ,,MD 21128 |
| ore, | of Hea fitem rother | | 20a. Method of Disposition | 7 P16 01 | 20b. F | | sition (Name of natory or other pla | - 1 | | ate | 20c. Location | | |
| Ĕ | Page 1 ment of tant: If it lury or o | | 1√ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec | ify) | S | T. JOS | | | 2-16- | -2012 | FULLER | TON. | MD. |
| Baltimore, | permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once. | | 21. Signature of Funeral Service Lyer | see | | | . Name and Addre | | lity SCH | | FUNERAL | HOME | E INC. |
| | #D = 60 | | 22g Dort 1 Catanaha disease ay con | | | | 05 BELAI | | | | AM,MD. | 21236 | |
| ١. | artedo tomo ve | | 23a. Part 1. Enter the disease, or con shock, or heart failure. List only of Immediate Cause (Final | one cause ach line | i the deati e. | n. Do not ente | r the mode of dyli | nu, such a | s cardiac or | respiratory arr | est, | | Approximate Interval Between Onset and Death |
| | hy i ian Medical | | disease or condition resulting in death) | a. Due to (or as | 011 | nde | toral | | un | ce_ | | -1 | Shock and Beath |
| | Examiner | | | Due to (or as | a consequ | ierice oij. | | | | | | | |
| | | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as | a consequ | ience of); | | | | | | | |
| 2 | cuted nd transi | Examiner | Cause (Disease or injury that initiated events | С. | | | | | | | | | |
| | ite be executed hysician and the burial-transit | alE | resulting in death) Last | Due to (or as | a consequ | ience of): | | | | | | | |
| 260 | cate b physi | edical | | d | | - | | | | | | | |
| Box 687 | the Hospital or Attending Physician: The law requires that the death certificate be executed that 4 hours after dath. The Abours after dath. The Funeral Director, dath. The Funeral Director, again and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | | | | | | 23d Da | te of delive | env |
| 30X | e atte | sicia | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 Live Birth 4 Pregnant a | | | Ectopic pregnan Other (specify) _ | су | | | | | Day Year |
| 0 | t the c by th | Phys | 9 Unknown | 9 ∐ Unknown | | | | | | Т | | | |
| Records, P.O. | requires that the des | þ | Part II. Other significant conditions | ontributing to death b | ut not res | ulting in the ur | nderlying cause gi | ven in Par | t I. | | | | ne cause of death? |
| rds | equire | Completed | | - | | | | | | | | _ | pably 4 Unknown |
| ၀၀ | has b | Мр | | | | | | | | 24a. Was a autop | sy | Nere autop orior to cor death? | osy findings available mpletion of cause of |
| m — | nysician: The law in secrificate has kolinector, page 2 s | | 25. Was case referred to medical | | | | _ | | | 1 Yes | | Yes | 2 No |
| /ita | sicial certi | To Be | examiner? | Hospital: | | ER/Outpatien | Oth | er. | ath (Check | | | | |
| of | ig Phy er this neral o | | 27. Manner of Death | 28a. Date of inju | ry | 28b. Time of | 28c. Injur | y at | | 7 | ence 6 - Othe | | |
| on | endin sath. or, Aft he fur | fical | Natural 5 Pending Accident Investigatio | n | i, 19ai) | injury | M 1 🗆 | <br Yes 2 | □No | | | | |
| Division of Vital | or Attending P ifter death. Virector, After t in by the funera | Certificate: | 3 ☐ Suicide 6 ☐ Could not to determined | 28e. Place of Inju building, etc | ry - At ho . (Specify) | me, farm, stre | et, factory, office | | 2 | 8f. Location (Si City or Town | treet and Number 1. State) | er or Rural | Route Number, |
| ے | pital o | | 20- Cariffee d Floorities Plan | To the best of | | | | | | | | | |
| : | To the Hospital or A within 24 hours after To the Funeral Dire completely filled in the | Medical | (Check 2 Medical Exam | sician: To the best of iner: On the basis of ease Practitioner: To the | xamination | and/or investi | gation, in my opini | on, death o | occurred at t | he time, date ar | nd place, and due | to the cau | ise(s) and manner stated. |
| | To the within To the Comp | 2 | 29b. Signature and title of certifier | se Fractitioner. To the | e Dest Of II | 10 Milowiedge, | 29c. Licens | | ate and plac | | e cause(s) and m 29d. Date signed | | |
| | | | 1/100/1 | NA | 7- | ~10 | D | 15 | 8- | 77 | Feb 1 | 2 | > 01> |
| | 1401 | | 30. Name and address of person who | completed cause of de | eath (Item | 23a) (Type, Pi | int) | 01 | 1 | 11 | 0 | 1 | 21061 |
| | W, | | 31. Date filed (Month, Day, Year) | 6934 | A | 1,26 | n'us i | 13/1 | 1 | Hen | BUP | DIP | - 00/ |
| | Stat Registra | .е | FEB 1 7 2012 | 32. Registra | ar's Signati | ure | . / | | | | | • | |
| | 3,0410 | | | Jan Marie | 19 | JE CARL | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death $\overset{\text{Day}}{1}2.20\overset{\text{Ye a}}{1}\overset{\text{a}}{2}$ **Physician** CATHERINE MARIE LANE FEBRUARY 3:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE FUTURE CARE CANTON If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 12-11-1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Davs Hours Min Country) MARY LAND 219-30-7386 78 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Mcdical Exert in the cast by matter a ¥ Yes 2 □ No Director MD. BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 USA Funeral 608 UMBRA STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2♠No 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6TH College (1-4or 5+) HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CATHERINE KERN LAWRENCE NEFF 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. JEANNE FRANCE DTR. 337 UPPER LANDING ROAD ESSEX, MD. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State OAKLAWN CEMETERY 2-15-2012 BALTO. MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign the of Funeral Servic Licensee CHARLES S. ZEILER AND SON, INC. 22. Name and Address of Facility T 6224 EASTERN AVENUE BALTO.MD. 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or 4 a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Sinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a.. autopsy performed? Ves 2 2 No 2 🗆 No 1 ☐ Yes 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

requires that the death certificate be execu-Box 68760, P.O. Records, Division of Vital

the attending physician ģ signed by t peen has page 2 s To the Hospital or Attending Physician; The certificate funeral director. this After t hours after death. Director: the filled in by 24 hours a completely the

show

death with

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Health and Mental Hygiem 27 is marked other

and

the as

use

3altimore, Maryland 21215-0036

State Registrar

2

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

title of certifier

(Check only

29b. Signature and

31. Date filed (Month

one)

1 7 201

and manner stated.

M.D

Avenue 32. 'Registrar's Signature

29d. Date signed (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1) 0055171

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Feb. Physician/ Tien-Bing Lin 13, 0612 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital 00 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours (Month, Day, Year) **Director** 1 🛣 M 2 🗆 F 93 137-92-2258 July 7, 1918 China 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 2/13/2012 filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Rockville MD Montgomery 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 20850 USA 95 Dawson Ave. Apt 309 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Asian Completed 3 Divorced 4 Divorced Year or Dates th and Mental Hygiene.

27 is marked other than "natur traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Security Guard Industrial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပု Wei Kwei-Sun Lin Chung-Jung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to 2420 Henslowe Dr. Potomac, MD 20854 Herbert Yeou Horwin Lin/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 2/16/12 Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Respiratory Onset and Death Immediate Cause (Final Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Preumonia Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s after death.

I Director, After this certificate has been siden by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 1 npatient 2 ER/Outpatient 3 DOA ၉ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Matural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after dear To the Funeral Director completely filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: Of the basis of examination and of infosegation, many spaces, and gate and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D0064502 February 13,2012 of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20850 9901 Medical MD Car Dr 31. Date filed (Monti State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lucille R. Lemmon 5:30a M Feb 16 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 1011 Hewitt Way Social Security Number 8. Date of Birth (Month, Day, Year) Dec . 26 , 1917 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 296-03-8262 Director 1 □ M 2 📑 Ohio 94 Yrs Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1011 Hewitt Way 21205 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural". 3 Widowed 4 Divorced Specify: White Completed Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene.
7 is marked other than "1 Elementary/Secondary (0-12) College (1-4 or 5+) Buyer Hecht Company 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gregory Elizabeth Reatarquino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Elizabeth Lemmon/daughter 1011 Hewitt Way Baltimore MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 2/18/12 Rossville MD 22. Name and Address of Facility 300 Mace Ave. Balto. 21. Signature of Funeral Servical Icenses Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phymician/ ADVANCED ALZNEIMER'S DISEASE disease or condition WKS. Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes ∠ 🗷 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NON-INSULIN DIABETES MELLITUS Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed CEREBROVASCULAR ACCIDENT 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? HYPERTENSION certificate ☐ Yes 2 🗷 No 1 Yes 2 X No 25. W case referred to medica the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛣 No 은 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0017728 M.D.

Registrar

DHMH 17 Rev 06-2011

8022 BELAIR RD. BALTO. MO 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OUNG

2012

M.D.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month - OW CS 035 DAM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Ac. County of Death **Examiner** 7.0 25 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 ★ M 2 □ F Months Hours Min 08/13/1927 240-48-8381 S.Carolina 84 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No N/A MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 804 Leadenhall 21230 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Was Deceden 2.2. Armed Forces? 1 ⊶ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) years Operations Research Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be t Department of Health and Ments Important: If item 27 is marked Earl D. Lowery Sr. Hannah D. Kelley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Lowery(Wife) Leadenhall St., Baltimore, MD 21230 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) injury or 1

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Garrison Forest 02/22/12 Owings Mills, MD 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home PA any 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Phylician disease or condition no Medical resulting in death) Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in literal are or linjury) Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the sid be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a Was an has autopsy performed 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one Signature and title of certifier 29c. License number 11,2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) onover street

Registrar DHMH 17 Rev 7/2009

State

001

egistrar's Signat

Ledbetter, Genevieve H Division of Vital Records, P.O. Box 68760

| | | | | Please | | | | | | | | | • | | e Legibl | e. | | |
|---|--|----------------------------------|---|--|---|--|-------------------|--------------------|-------------------|--|--------------------------------|---|----------------------|----------------------------|---------------------------|------------------|----------------------|------------|
| | | - | State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg No. 2 1 | | | | | | | | | 2 | nI. | 540 | | | | |
| | | | 1. Decedent's Name (First, Middle, Last) | | | | | | | .0 07 2 | | | 2. Date of De | | | <u>f-m</u> | 3. Time of | Death |
| | Physicia Medic | | Genevie | | Ledt | | er | | | | | | Feb | 1 | Day Year 7:05 PM | | | |
| | Examir | er | Belair Health and Rehabilitation Center Bel Air Har For | | | | | | | | | | nd | (04-4- | | | | |
| | Funeral Director | | 220-14- Usual Residence of | 5303 | — M 2 M F | = //. Age | 88 | Yrs. | Months | | Hours | | 8. Date of Bi | , Year | 23 Ma | Entriple ST'y | lce (State o Land | or Foreign |
| | yland f show ed at | tor | 10a. State | 10b. County Balti | | | · · | , Town or | | | | | | | | 100 | d. Inside C | |
| | or 28a- notifie | Direc | Md. | Not | Nottingham | | | | | | 100.0 | itizen of What | Countr | | 2 X No | | | |
| | with the s 23a c ust be | eral | 12 Love Lock Court 21236 U.S.A. | | | | | | | | | Countr | <i>y</i> . | | | | | |
| 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Be Completed by Funeral Director | 11. Marital Status 1 ☐ Never Marri 3 ※ Widowed | ecedent E Forces? es 2 X Give Dates. | Ever in U.S. 13. Was Decedent of Hispanic Origin? (Single of the second of Hispanic Origin?) 13. Was Decedent of Hispanic Origin? (Single of the second of Hispanic Origin?) 14. Was Decedent of Hispanic Origin? (Single of the second of Hispanic Origin?) 15. Was Decedent of Hispanic Origin? (Single of the second of Hispanic Origin?) 16. Was Decedent of Hispanic Origin? (Single of the second of Hispanic Origin?) 17. Was Decedent of Hispanic Origin? (Single of the second of Hispanic Origin?) 18. Was Decedent of Hispanic Origin? (Single of the second of the second of Hispanic Origin?) | | | | | | cify Yes or No Rican, etc.) | | hite, et | indian, | | | | |
| 5-0 | 2 hour "natur | plete | (Spe | 15. Decedent's E cify only highest gr | ducation | 16a. Decedent's Usual Occupati (Give kind of work done du | | | | | | ost of workir | ng | 16b. | Kind of Business Industry | | | |
| 2121 | vithin 7 iene. ir than the M | Com | Elementary/Seco 10 | (1-4 or 5 | -4 or 5+) life. DO NOT use retired) Clerk | | | | | | т & т | · Τ | | | | | | |
| Maryland 2 | d be filed v Mental Hyg arked othe | To Be | 17. Father's Name (f | | | | | | | | | Name (First, Middle, Maiden Surname) ephine Dudka | | | | | | |
| Man | shoul h and l 7 is ma traums | | 19a. Informant's Na | | | | | 1 | _ | | | | | | or Town, State, | | | 0100 |
| re, | l and 2 f Healt item 2 other | | Joan Di 20a. Method of Disp | Tommas s | so/Dau | ught | 20h P | lace of Dis | enosition (Na | me of | | Fohr | | | am, Ma | | | 2123 |
| mo | Page 1 nent of ant: If i | | | ☐ Cremation 3 ☐ 5 ☐ Other (Speci | | om State | St | emetery, c .Sta | rematory or a | other plac NUS | Čem | 15, | | | timor | | | and |
| Baltimore, | permit. Departr Imports any inju | | 21. Signature of Fur | nera Service Licen | see | M | 1009 | | | | | | | | Funera imore | | | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | Approximat nterval Bet | te ween | | | |
| | executed Medical an and uial-transit | | Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): | | | | | | | | | | Onset and | Death | | | | |
| Division of Vital Records, P.O. Box 68760 | | L | Sequentially list co. | nditions | h | | | | | | | | | | | | | |
| | | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury | | | | | | | | | | | | | | | |
| | | Exa | | | | | | | | | | | | | | | | |
| | cate be o | dica | | | d | | | | · · | | | | | | | _ | | |
| | death certifice the attending produced for use as to | Completed by Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | | | | | | | | | | 23d. Date of Month | | | Year | |
| | requires that the de been signed by the should be detached | y Ph | | e underlying | derlying cause given in Part I. 23e. D | | | | | id tobacco use contribute to the cause of death? | | | | | | | | |
| | quires en sign | ted k | 1 □ Yes 2 🗷 No | | | | | | | | | 2 X No 3□ | 3 Probably 4 Unknown | | | | | |
| | The law re cate has be page 2 shr | Comple | 24a. Was an autopsy prior prior deat 1 | | | | | | | | | | to com | y findings pletion of c | | | | |
| | sician: The la certificate hi irector, page | Be C | 25. Was case referre examiner? 1 ☐ Yes 2 ▼ | ed to medical No | Hospital: | | | ED/0 | | Oth | | eath (Check | | | | | | |
| | Hospital or Attending Phys 24 hours after death. Funeral Director: After this sted filled in by the funeral di | te: To | 27. Manner of Death | | 28a. Date of injury (Month, Day, Year) 28b. Time of injury work? 1 □ Yes 2 □ No | | | | | | 1 | ng Home 5 Residence 6 Other (\$ 28d. Describe how injury occurred | | | | | | |
| | | Certificate: | 1 Natural 2 Accident 3 Suicide | 5 ☐ Pending Investigatio 6 ☐ Could not b | | | | | | | _ | | | | | | | |
| Sivis | | Cer | 4 🗌 Homicide | determined | 286. Place of Injury - At nome, farm, street, factory, office 28f. Locat | | | | | | | cation (Street and Number or Rural Route Number, y or Town, State) | | | | | | |
| | | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) are only one). 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | anner stated. | | | |
| | To the within To the comple | _ | only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and 29b. Signature and title of certifier 29c. License number 29d. Date signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHICH KHOSCH 615 W.MACHHILL RD 4106, BEL ALR 31. Date filed (Month, Day, Year) 32 Registrar's Signature 33 Registrar's Signature | | | | | | | | ate signed (Mo | ed (Month, Day, Year) | | | | | | |
| _ | | | 30. Name and addre | ess of person who | completed ca | ause of de | eath (Item い・M | 23a) (Type | e, Print) HAIL | RD | #10 | 6, 6 | EL F | FIR | MD | 2 | 1011 | † |
| | Sta Registr | te ar | 31. Date filed (Month | EB 1 7 20 | 12 32 | legistre | ar's Signat | 1. 4 | ares | • | | | | | | | | |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Paul George Morin, Sr. 16 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale
If Under 1 Year | If Under 24 Hrs. FRANKLIN SQUARE HOSPITal Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**X**M 2□ F 218-28-0674 80 September 19,1931 Columbus, Chio Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Extrainment be rediffied at once. 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Parkville 1 □Yes 2X No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21234 3032 Arizona Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No δ Specify: White 3℃Vidowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Computer Customer Engineer 12 Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth A. Traversy Joseph P. Morin, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Beall (Daughter) 3032 Arizona Avenue Parkville, Maryland 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 21, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park Parkville, Maryland 4 □ Donation 5 □ Other (Specify) 2012 Signature of Flurieral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville 0 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumonic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed nis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 1√0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ax GOOD FRANKLIN SQUARE DR Balto Md 21237 Ahmed DR Kirmand 31. Date filed (Month, Day, Year) State **FEB 17**

DHMH 17 Rev 1/2001

Registrar

12-01325

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Michael Joseph Murphy 1- For State Certificate of Death Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 14, 2012 0953 hrs Joseph Murphy Michael Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Monkton **Baltimore County** 329 Everett Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or January 30, Foreign Balt., If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Balt., Countinaryland January Months Days Hours Min. Director 213-68-4005 1 X M 51 Yrs 1961 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 XXNo Monkton Baltimore Maryland If kem 27 is marked other than "natural", or items 23a or 23a-f shov her tranmatie event, the Medical Examiner must be notified at once. filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21111 329 Everett Road of America 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 X Never Married 2 Married 2 XX No 1 Yes white Yes 2XX No specify: Specify 3 Widowed 4 Divorced f Yes, Give Yea \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Disabled Disabled 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pansy Faye Davis Michael Anthony Maruffi B es I and 2 should be fi of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Perry Hall, Maryland 21128 Mr. Gregory J. Maruffi/ brother 8829 Cowenton Avenue 20c. Location - City or Town, State Baltimore, I permit. Pages I and Department of Healt Important: If them injury or other transing. 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, February Burial 2 XXCremation 3 Removal from State Evans Funeral Forest Hill, Maryland 16, 2012 Donation 5 Other Specify. Chapel- Bel 22. Name and Address of Facility of Funeral Service Ligens Peaceful Alternatives Funeral and Cremation Center, P.A.

2325 York Road Timonium, Maryland 21093

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Approximate Inten Approximate Interval Physician Between Onset and failure. List only one cause on each line Death √Medical a Contact Shotgun Wound of the Head Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** attending physician for use as the burial -23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Dav Year 1 Live birth Fetal death led by the attending detached for use as 1 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? signed by the detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed page 2 should 24a. Was en 24b. Were autopsy findings available has been autopsy prior to completion of cause of performed? ✓ Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject shot self Certification FOUND 1 Natural 1 Yes 2 V No Pending death. the Director: Feb 14, 2012 0948 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City n 24 hours after d e Funeral Direc filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 329 Everett Road , Monkton , MD determined (Specify) Single Family Home Homicide 29a. Certifier To the Hosp within 24 ho To the Func completely f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. February 15, 2012 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Victor Weedn MD JD Assistant Medical Examiner 31. Date filed (Month. FEB Registrar

DHMH 17 Rev 1/2001

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| | | | | Pleas | e Type or F AMEND State of #27,28 | rint in E | Black In 3a pt I | delible Inl | k. Ens G924, | and M | II Copie | es Are Le | gible. | | |
|-----------------------------|--|-------------------------------|--|---|--|--------------------------------------|-----------------------|--|---------------------------|--------------------------|--------------------------------|---------------------------------|--|--|--|
| | | | For State Registrar | | #27,28 | a-f | Cen | ificate of L | Death | and iv | ioritai i i | Reg. No. 2 | 012 | 04643 | |
| | Physicia Medic | | 1. Deadent's Name | (First, Middle, L | Macke | 211_ | | | | | 2. Date of D Month Febru | Day | 2011 | 3. Time of Death 3.5/ // MM | |
| C | Examir | | 4a. Facility Name (if) Sinai | not institution, gi | a of Ba | Itimo | ove | 4b. City, Town, or Balt | Location | | ity | 4c. Cour | ty of Death | | |
| | Funeral Director | | 5. Social Security Nu 214-56- Usual Residence of | 6055 | st birthday) Yrs. | If Under 1 Year Months Days | If Under Hours | Min. | 8. Date of B (Month, D | ay Year) | 9. Birthp Coun | place (State or Foreign try) | | | |
| | ıryland ı-f show ïed at | ctor | 10a. State 10b. County 10c. City, Town or Location Baltimore | | | | | | | | | 1 | 10d. Inside City Limits 1 | | |
| | death with the Maryland r items 23a or 28a-f sho iner must be notified at | Funeral Director | 10e. Street and Num | | . Aia | | <u>um/</u> | 10f. Zip Code | 21/ | | | 10g. Citizen o | f What Coun | | |
| | leath wi | Fune | 11. Marital Status | un vie | 12. Was Decede | ent Ever in U.S. | . 13. W | as Decedent of Hi Yes, specify Cuba | ispanic Or | igin? (Spe | cify Yes or No | | ace - Americ | | |
| Ka / 0036 | ours after o ttural", or al Examin | eted by | 1 Never Marrie 3 Widowed 4 | | 1 ☐ Yes 2 If Yes, Give Year or Date | No | 1 | ☐ Yes 2 ☑ No | Specify | | nicari, etc.) | Speci | ack, White, 6 | ck | |
| 1215- | nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at ite. | Completed | (Spec | ent's Usual Occup nd of work done of NOT use retired) | during mos | st of workir | So. Kind of | ocial Security aministration | | | | | | | |
| R Λ land 2 | | To Be (| 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symbol Symb | | | | | | | | | | | | |
| 35 Z laryla | should be and Ment is marker aumatic e | | Jea Informant's Nar | me/Ralationship | (Type, Print) | <u>-しノ</u> | 19b. Mailing | Address (Street a | and Numb | uth Fr or Rural | Route Numb | er, City or Town, | State, Zip C | Code) | |
| I'MC | permit. Page 1 and 2. Department of Heath Important: If item 27 any injury or other tr | | June C. 20a. Method of Dispo | | all (W | | 4408 ace of Dispos | ition (Name of | 1 | | Bab Pate | Fimore 20c. Location | - City or To | | |
| \mathcal{H}_{I} Baltimore | | | 4 Donation | 5 Other (Spec | N. CA | | netery, crem | tory or other place | :e) | 2-2. | 2-2012 | Mind | sork | any, IT | |
| Ba | | | 21. Signature of Fun | era Service Lice | Freez | ٩ | 51 | Si Bu | ss of facili | Nat | 1 Pil | unera | 279) | vices | |
| | Physician | | 23a. Part 1. Enter the shock, or heart Immediate Cause (F disease or condition | failure. List only inal | mplications that cau one cause on each | ised the death. line. | . Do not enter | the mode of dying | g, such as | . 25 | respiratory a | | | Approximate Interval Between Onset and Death | |
| | Medical Examiner | | resulting in death) | (| a. Due to (or | as a conseque | ence of): | eratic | he | nfa | | ase (| | 10/21 | |
| | ed nsit | Examiner | Sequentially list con if any, leading to im- cause. Enter Underli- Cause (Disease or in | ditions, nediate ying | Due to (or as a consequence of): | | | | | | | | | , | |
| - | e executed cian and ourial-transi | l = 1 | that initiated events resulting in death) La | | C. Due to (or | as a conseque | BY MEDICAL EXA | MER | | | | | | | |
| 8760 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | To Be Completed by Physician/ | IF FEMALE: | | d | | | | | ERTIFICATI | Water | Т | | | |
| . Box 68760 | | | 23b. Was decedent printhe past 12 mm 1 Yes 2 9 Unknown | onths? | | th 2 Tetal nt at time of de | death 3 | Ectopic pregnanc Other (specify) | y | | | | ate of delive Month | ry Day Year | |
| , P.O. | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Did betes Mellitus, Pelvic Fracture 23e. Did tobacco use of the property of the property of the part I. 24a. Was an autopsy | | | | | | | | | | | | |
| of Vital Records, | | | | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of | | |
| l Rec | | | 25. Was case referred | to medical | | | | 00 81 | (D | | perf | ormed? 2 No | death? | | |
| Vita | | | examiner? 1 ☑ Yes 2 ☐ | | Hospital: | patient 2 🗆 E | R/Outpatient | LOtho | | ath (Check ursing Hor | | idence 6 🗆 Ot | her (Specify) | manara | |
| on of | | | 27. Nanner of Death S Natural 2 X Accident | 5 Pending | | injury <i>Day, Year)</i> •2012 | 28b. Time of injury | 28c. Injury work' M 1 | | 1.1. | 8d. Describe subjec | how injury occu | rred | | |
| Division | Hospital or Attendi 24 hours after death. Funeral Director: A etely filled in by the fu | | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not determined | 28e. Place of | | | t, factory, office | ^ | 2 | 8f. Location (City or To | Street and Num wn, State) 44 | | Route Number, rview Ave. | |
| Δ | Hospital or 24 hours afte Funeral Directely filled in | Medical | 29a. Certifier 1 1 (Check 2 | Certifying Ph | ysician: To the best | of my knowle | edge, death oc | curred at the time | e, date and | place, an | d due to the o | re, Mary | nner as state | d. se(s) and manner stated. | |
| | To the F within 24 To the F complet | Me | only one) 3 [29b. Signature and ti | Certifying Nu | rse Practitioner: To | | | | he time, da | | | | manner as s | tated. | |
| | nn n | | 1 0 | 78 | quer | 14 M | <u>S</u> | 0000 | 2473 | 16 | | Febru | arr | 15 2012 | |
| | 54 | | 30. Name and address | | se Seg | ueit | 23a) (Type, Pri | nai Ho | spil | talo | f Ba | ttim | ore | | |
| | Stat Registra | | 31. Date filed (Month, | 2012 | Server 32. Régi | strar's Signatu | re May | | 1 | | <i></i> | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 2012 2:15AM Feb Mary Louise Marshall Medical 4a Facility Name (if not institution, give street and number) ive 18101 Prince Philip Drive MedStar Montgomery Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Olney Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 1 M 2 X F Days Hours Min Director 213-56-5209 60 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f 1X Yes 2 ☐ No MD Olney Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 18131 Marksman Circle 20832 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 5 1 Never Married 2 Married 1 ☐ Yes 2 🛭 No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 Divorced Completed Black Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Secretary County Gov't 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Richard George Marshall Willie Hortense Lee 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20874 12914 Pickering Drive, Germantown, Tracee Lee Marshall 20b. Place of Disposition (Name of Sch cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or or once. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Med. 2/14/2012 Washington, DC Howard Univ. 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ nterstitial resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to initial ediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Dusity (or as a c ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 for in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ≠ 9 ☐ Unknown the detached Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy perform certificate Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify after death. Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours

State Registrar 29a. Certifier (Check

only one

31. Date filed (Mor

29b. Signature and title of certifier

Bichkun

30. Name and address of Person who completed cause of death (Item 23a) (Type, Prin Bichhuong M. Dinh 1810 D

within 2

legistrar's Signatur

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Philip

29d. Date signed (Month, Day, Year)

febracar 4

Olney

Drive

2012

208 32

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Prince

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 14,2012 2:25P M Angela C. Molino Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto. Stella Maris Timonium If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) Country **Director** 213-03-3005 1 🗆 M 2 🗓 F 86 June 15,1918 Maryland Usual Residence of Deced 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits 72 hours after death with the Maryland must be notified at Director 1 🗌 Yes 2 💢 No Md. Balto. Perry Hall 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a 21128 USA 9821 Fox Hill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Label Maker 6th Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Maria Illardo Anthony Culotta FEBRUARY 14, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fox Hill Road Perry Hall, Md. 21128 Carol A. Cuneo 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Gardens of Faith 2-18-2012 Balto. MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ea, h line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) been signed by the atter should be detached for in the past 12 months?
1 Yes 2 No Year Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2-No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has 1 Yes 2 No Yes MOLING completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 XNo ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4-X Nursing Home 5 - Residence 6 - Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work? 1 Katural 5 Pending ☐ Accident Investigation ANGELA 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature a 29c. License number ess of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, 2300 DULANEY VALLEY ROAD M.D.TIMONIUM 21093 MD31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

FEB 17

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04646 State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Morris Barbara 5:00 PM 050 20/2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Baz Hopkins Baltimore Care Center view 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 😾 F Hours August 20, 1919 220-07-1138 92 Pennsylvania **Director** Usual Residence of Decedent ıtal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 326 Kane Street 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc ģ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8 t h College (1-4 or 5+) and Mental Hygien Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Camillo DeSantis Page 1 and 2 should be ment of Health and Menta Julia Mari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Gilbert Morris Son 11-L Brook Farm Court Perry Hall, Md. 21128 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State 2-18-2012 Balto. Md. 4 Donation 5 Other (Specify) Oaklawn Cemetery Signature of Juneral Service Licensee 22. Name and Address of Facility Charles S. zeiler and Son, Inc. 6224 Eastern Avenue Balto.Md.21224 art 1 Ept. r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia 0 years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year Pregnant at time of death 1 L Yes 2 L 9 Unknown is been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: P 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No To the Hospital or Attendi within 24 hours after death. To the Funeral Lirector: A Investigation the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) okin Baywiew Circle Baltimore MD 21224 5505 $m \bigcirc$ 31. Date filed (Month, Day, Year) State B Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day MELTON ROBERT 1437 Medical Feh 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Olney 5. Social Security Number If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Dec 28, Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🔀 M 2 🗆 F Director 69 Indiana 1942 307-44-2392 Dec. Usual Residence of Deceden 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director MD Montgomery Silver Spring 1 Tes 2X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20906 14510 Homecrest Road #4028 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 Yes 2 😾 No 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) <u>Administrator</u> **IBM** 4 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Lucille Emma Grimmeissen Merle Clyde Melton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Richard A. Melton / brother 708 Lodge Ave. Evansville, IN 47714 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/17/12 Woodbine, MD 21. Signature of Funeral Service Lice Coing Home Cremation Service P.O. Box 784 any Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Obstructive Pulmonary Discare 24b. Were autopsy findings available prior to completion of cause of death? Was an page 2 s autopsy perform certificate Yes 2 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 PER/Outpatient 3 IDOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 24 hours after death. Funeral Director: A 1 Tyes 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2. To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 00060319

DHMH 17 Rev 7/2009

State Registrar 18101 Prince Philip Dr. Olney, MD 20832

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

| idlew willer | | 1- For State Certificate of Death | | Reg. | 201 | 2 0464 |
|--|----------------|--|--|------------------------|---------------------------------|--------------------------------|
| Physici | | Registrar 1. Decedent's Name (First, Middle,Last) | 2. | . Date of Death | | 3. Time of Death |
| ledical Exam | iner | Andrew Carl Miller | | Month E February 14 | | 1220 hrs |
| | | | wn, or Location of Death | | 4c. County of Death Harford | |
| | | Upper Chesapeake Medical Center Bet Air 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under | | 8 Date of Birth | (MM/DD/YYYY) 9. Birl | holace (State or |
| Funeral Director | | 213-61-8011 12M 2 F 10 Yrs. Months | Days Hours Min. | May 16, | Foreig | |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | | 10d. Inside City Limits |
| E-32 | _ | Maryland Harford Bel Air | | | | 1 Yes 2 No |
| Aaryland 28a-f show | Director | 10e. Street and Number 10f. Zip C | ode | 10g | . Citizen of What Cour | ntry? |
| the N | 2 | 706 Tobacco Run Drive 21 | 015 | | USA | |
| h with | Funeral | | t of Hispanic Origin? (Spec Cuban, Mexican, Puerto Ri | | 14. Race - Ameri White, etc. | can Indian, Black, |
| or deat | 필 | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No | T No. specific | | Specify: With | ito |
| irs afte iural" | þ | or Dates: | ccupation (Give kind of wor | rk done 1 | 6b. Kind of Business/l | ite |
| ; 72 hou a "nat | eted | | ing life. DO NOT use retired | d) | | |
| 5-0036 lled within 7 Hygiene. I other than | Comple | 5 Student | | | Elementary | School |
| filed v Hygi d other | | 17. Father's Name (First, Middle, Last) | 18.Mother's Name (F | | | |
| 2121 Mental Marked marked ic event, | To Be | Steven Carl Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address | Mildred (Street and Number or Rui | | | , Zip Code) |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marhal Hygiera. In them 77 is marked other than "natural", or items 23a or 23a-f she injury or other traumatic event, the Medical Examiner and to no fired at occasing the contract of t | - | | bacco Run Dr | rive, Be | l Air, Mar | yland 21015 |
| e, P 1 and 1 Health Fitem | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name crematory or other place) | of cemetery, | Date | 20c. Location - City or | Town, State |
| Pages ent of unt: U | | 4 Donation 5 Other Specify: Rose Hill Serv | ices, Ltc 2- | 17-2012 | Bel Air, M | aryland |
| Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr | | 21 Signature of Funeral Service Licensee 22. Name and A | ddress of Facility MCC | | | |
| | S 38 | 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of | kesbury Road | | | and 21009 Approximate Interval |
| Physician Medical | S 17 | failure. List only one cause on each line. | dying, sadir as cardiac or i | espiratory arres | t, stroot, or rear | Between Onset and Death |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | | | | |
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| so, te be execut sysician and | Medical | ☑ UNPENDED ☐ AMENDED 23a,27,per me,g924 | 2-22-12 sm | | 23d. Date of deliver | L |
| Box 6876 ne death certificate the attending phy hed for use as the | Ž | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death | 3 Ectopic pregnand | су | | Day Year |
| 5x 6 ath cer attendi | Sicia | 4 Pregnant at time of death 5 Other (Specif | 5⁄) | | Į. | |
| b. BC the des | Physician/I | Part II. Other significant conditions contributing to death but not resulting in the underlying c | ause given in Part I. | 23e. Did toba | acco use contribute to | the cause of death? |
| ires that the signed by 1 be detached | b | Solition and the soliti | | 1 Yes | 2 ✓ No 3 Prol | pably 4 Unknown |
| rds, require been si hould b | eted | | | 24a. Was an | | topsy findings available |
| e law i e has t ge 2 sh | Completed | | | autopsy perform | ed? death? | completion of cause of |
| Vital Rec ysician: The his certificate director, page | | 25. Was case referred to medical 26 | 6.Place of Death (Check on | | | 2 10 |
| Vita nysicia this ce | o Be | examiner? 1 ✓ Yes 2 No | Other Nursing | Home 5 R | esidence 6 0the | r: |
| ing Ph After t | ٦ | (Month, Day, Year) | , | 8d. Describe ho | w injury occurred | |
| ivisior or Attend after death. Director: | äţi | 2 Accident Investigation | 1Yes 2No | | | David Number City |
| Divisipital or At ours after derail Direct filled in by | Certification: | 3 Suicide 6 Could not be determined (Specify) | office building, etc. | or Town, Sta | | ıral Route Number, City |
| | | 4 Homicide (opecary) 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the t | time, date and place, and d | ue to the cause | (s) and manner as stat | ed. |
| To the How within 24 h To the Fur completely | Medical | one) 2 Medical Examiner:On the basis of examination and/or investigation, in my of and manner stated. | | | | |
| F 3 F 3 | Me | 29b. Signature and title of certifier 29c. | License number | | 29d. Date signed (Mo | nth, Day, Year) |
| -1 | | Cretor Saller Setter 1 | O.C.M.E. | | February 15, 20 | 12 |
| q | | 30 Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltim | ore Street, Baltimore | MD 21223 | | |
| | tate | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | ., III. 2 122c | | |
| Regis | | FED 17 2010 A | | | | |
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|-------------|----------------------------|--|-------------------------|--|--|----------------------------------|--------------------------|--|--------------------------|---|------------------|-----------------------------------|--|
| | | | | Registrar 1. Decedent's Name (First, Middle | , Last) | | 00. | tinicate of L | Jeani | 2. Date of D | | 0 1 6 | 3. Time of Death |
| | | Physicia Medic | | Kevin Patrick | McDermot | t | | | | Fe Month | nary 15 | , ZDIZ | 11:15AM |
| | بهامان | Examir | | 4a. Facility Name (if not institution | give street and nun | nber) | | 4b. City, Town, or | r Location | of Death | | inty of Death | 2000 |
| | | Europal | | Baltimore Washi 5. Social Security Number | ngton Med | | Center s. last birthday) | Glen Bu | | 24 Hrs. 8. Date of B |) Myn | | place (State or Foreign |
| | | Funeral Director | | 218-64-8278 | 1 X M 2 □ F | 58 | | Months Days | Hours | Min. (Month, D | lay, Year) | Count | ntry) |
| | | ld now | Ļ | Usual Residence of Decedent 10a, State 10b, County | | 100 | City, Town or Lo | cation | | 06/19 | /1953 | | Vriginia 10d. Inside City Limits |
| | | arylan a-f sh fied a | Funeral Director | | rundel | | en Burn: | | | | | | 1 Yes 2X No |
| | | the M or 28 e noti | ă | 10e. Street and Number | i under | 1016 | en buin. | 10f. Zip Code | | | 10g. Citizen | of What Coun | |
| | | s 23a | era | 200 Broadway | Ave | | | 2106 | 1 | | United | State | es. |
| | | ritem inern | | 11. Marital Status | 12. Was Dece Armed Fo | rces? | | Was Decedent of Hi If Yes, specify Cuba | ispanic Or an, Mexica | igin? (Specify Yes or No n, Puerto Rican, etc.) | | Race - America Black, White, e | |
| | 336 | s after al", o Exam | d by | 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🔀 Divorced | ied 1 X Yes If Yes, Giv Year or Da | 2 ∐ No re | | 1 ☐ Yes 2 X ☐ No | Specify | : | Spec | T 71. | ite |
| | 2-0 | hour hatur dical | olete | | it's Education st grade completed) | | 16a. Dece | dent's Usual Occupa kind of work done o | ation | A - F | 16b. Kind o | f Business/Inc | dustry |
| | 21215-0036 | than 72 | Completed | Elementary/Secondary (0-12) | College (1 | -4 or 5+) | life. D | O NOT use retired) | | a or working | 77100 | | |
| | d 2 | ed wit Hygie other ent, th | Be C | 12 17. Father's Name (First, Middle, L | ast) | | Carpe | et Instal | | ier's Name (First, Middle | | ring | |
| | lan | l be fill fental rked c | 2 | George F. McI | , | | | | | J. Mitche | | ine) | |
| | lary | should and N is ma auma | | 19a. Informant's Name/Relationsh | ip (Type, Print) | | 19b. Mailii | ng Address (Street a | and Numb | er or Rural Route Numb | er, City or Towr | n, State, Zip C | Code) |
| | 2, | and 2 seedth | | C. Rachel Fir | an/Sister | | | | Ave | Glen Burni | e, Mary | yland 2 | 21061 |
| | JOre | ge 1a nt of H : If ite or ot | | 20a. Method of Disposition 1 | 3 Removal from | State | | natory or other plac | | Date | | on - City or To | |
| # | Saltimore, Maryland | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 1 | 4 ☐ Donation 5 ☐ Other (\$ 21. Signatu e of Fue Nervic | | Me | etro Cre | | | 2/16/2012 | | sville | e, Maryland |
| Ó | B | Dep Imp any | | | N. | | K 142 | irkley-Ru 21 Crain | ddick Highw | t Funeral H May S.E. Gl | ome en Burn | ie, MD | 21061 |
| Z | | | | 23a. Part 1: Enter the disease, or shock, or heart failure. List o | complications that only one cause on ea | aused the de | | er the mode of dying | g, such as | cardiac or respiratory a | rrest, | | Approximate Interval Between |
| | - | h sician/ | | Immediate Cause (Final disease or condition | _ m- | efor | 87- F | i pon | ~ W | uptic (| en c | 2~ | Onset and Death |
| 2 | | Medical Examiner | | resulting in death) | Due to (| or as a conse | equence of): | 1 | | | | | |
| 3 | | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Otte to (| UF 88 G CUITES | squarico oij: | | | | | | |
| 5 | | ecuted and I-transit | Examiner | Cause (Disease or injury that initiated events | C | | | | | | | | |
| | | death certificate be executed the attending physician and ed for use as the burial-transit | dical E | resulting in death) Last | Due to (| or as a conse | equence of): | | | | | | |
| | 760 | hys the | ledic | | d | | | ·········· | | | | | |
| 5 | c 687 | ending use a | an/N | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, out | come of preg | nancy | Ectopic pregnanc | | | 23d. | Date of delive | ery |
| > | Вох | death the att | by Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 Pregi | nant at time c | of death 5 | Other (specify) | · y | | | Month | Day Year |
| 4 | P.O. | that the ned by the e detach | / Ph | Part II. Other significant conditio | ns contributing to de | eath but not r | esulting in the u | nderlying cause giv | ven in Part | I. 23e. Did | tobacco use co | ontribute to th | ne cause of death? |
| | | requires that the death certifica been signed by the attending p should be detached for use as i | iq p | | | | | | | 1 🗆 | Yes 2 No | 3 Prot | oably 4 🗆 Unknown |
| | Sorc | iw req | Completed | | | | | | | 24a. Was | | b. Were autop | osy findings available impletion of cause of |
| | Rec | sician: The law r s certificate has b lirector, page 2 s | Com | | | | | | | perf | ormed? | death? | 2 N/No |
| | ţa | ician: certific rector, | Be | 25. Was case referred to medical examiner? | Hospital: | | | | | th (Check only one) | ? | | / |
| | <u>></u> | Phys r this or | 일 | 1 Yes 2 No 27. Manner of Death | 28a. Date o | | ER/Outpatier | t 3 DOA Othe | 4 ∐ Nı | ursing Home 5 Res | idence 6 🗆 O | 1-1-1-1 |) |
| | n C | nding ath. r: Afte ne fune | icate | 1 Natural 5 ☐ Pending 2 ☐ Accident Investig | (Mont | h, Day, Year) | injury | work' | ? Yes 2 | | now injury occi | ired | |
| | Division of Vital Records, | l or Attending Physician: The law requires after death. Director: After this certificate has been sign in by the funeral director, page 2 should be | Certificate: | 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi | 28e. Place | of Injury - At ng, etc. (Spec | home, farm, stre | eet, factory, office | | 28f. Location (| | nber or Rural i | Route Number, |
| | ۵ | pital o | | 29a. Certifier 1' Certifying | Physician, To the h | not of my leno | unical condition | | | | | | |
| | | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director, | Medical | (Check 2 🗀 Medical 🗷 | teminer: On the basi | is of examinat | ion and/or invest | igation, in my opinio | n, death or | place, and due to the occurred at the time, date te and place, and due to | and place, and | due to the cau: | use(s) and manner stated. |
| | | Vithir Comp | _ | 29b. Signature and title of certifier | 0 V | ~ d | | 29c. License | | , | 29d. Date sign | | |
| | | | | 83 | 7 ' | ''' | | 1148 | 300 | b | 041 | 5/2 | 2012 |
| \vec{l}_i | | | | 30. Name and address of person w | USU- F | e of death (Ite | 23a) (Type, P | (VE) | 170 | spital. | Ar-1 | Cole | n Barni |
| V | | Stat | е | 31. Date filed (Month, Day, Year) FEB 1 7 20 | 32. Re | egistrar's Sign | nature | | ., | -/ | 1 | | |
| 4/ | | Registra | r | ED 1 7 20 | L. Berel | u A. | Back | | | | | | |

D/110//1 17 (16 / 00-20)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | . 101 | partment of Health and N | Mental Hygi | | OLCEO |
|----------------------------|---|--------------|---|--|--|---|--|
| | | | State Registrar C6 | ertificate of Death | Re | g. No. 2012 | 2 04650 |
| | Physicia | -/ | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day Year | 3. Time of Death |
| | Medic | | Joseph James Miller, Sr. | | February | Day 2012 | 8:00 P ^M |
| | Examin | er | 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Dea | |
| برجيبيه | | | Morningside House of Friendship 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday | Hanover If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | Anne Ar | |
| | Funeral Director | | 212-02-77/1 | Months Days Hours Min. | (Month, Day, Y | | irthplace (State or Foreign ountry) |
| | | 0 | Usual Residence of Decedent 92 Yrs. | | Jan. 1, | 1920 M | Maryland |
| | rland f sho | tor | 10a. State 10b. County 10c. City, Town or I | Location | | | 10d. Inside City Limits |
| | Many 28a- lotifie | Director | MD Anne Arundel | Jessup | | | 1 ☐ Yes 2 🛣 No |
| | th the | alD | 10e. Street and Number | 10f. Zip Code | | g. Citizen of What C | , |
| | ms 2 must | Funeral | 2820 Jessup Road | 20794 | | Jnited Sta | |
| ' | or dea | | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No | . Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto | Rican, etc.) | 14. Race - Am Black, Whi | |
| 036 | s afte ral", | q pe | 3 X Widowed 4 □ Divorced If Yes, Give Year or Dates 1944-1946 | 1 ☐ Yes 2 🕅 No Specify: | | Specify: Wh | ite |
| 21215-0036 | hour fnatu dical | Completed by | 15. Decedent's Education 16a. Dec | edent's Usual Occupation e kind of work done during most of work | ring 1 | 6b. Kind of Busines | s/Industry |
| 7 | nin 72 he. han ' e Me | mo | Elementary/Secondary (0-12) College (1-4 or 5+) | DO NOT use retired) | | | |
| 2 | d witl lygier ther I | Be C | 12 – Mana | gement Specialist | | | of the Navy |
| anc | ntal Fred o | To E | 17. Father's Name (First, Middle, Last) | | ne (First, Middle, Ma | iden Surname) | |
| Maryland | should be filed whand Mental Hyg 7 is marked othe traumatic event, | | John Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Ma | Annie ' | | Straw Town State 7 | Tip Code) |
| | 27 is | | | Coronet Drive Lin | | · | |
| Ē, | 1 and if Hea item othe | | 20a. Method of Disposition 20b. Place of Disposition | position (Name of | | Oc. Location - City of | |
| E | Page nent o int: If ry or | | 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cremetery, cr Mean 13 4 ☐ Donation 5 ☐ Other (Specify) | ematory or other place) Owridge LI Park 2–22 | -2012 E | lkridge, | Marvland |
| altimore, | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | | 22. Name and Address of Facility Donaldson Funeral | | | |
| m | 8 2 E 8 | - 1 | Office Clarges | 1411 Annapolis Roa | d Odenton | ı, Marylar | nd 21113 |
| | | | 231. Part / Enter the disease, or complications the caused the death. Do not enter the disease, or complications the cause on each line. | | or respiratory arrest | ., | Approximate Interval Between |
| - 1 | Physician/ | | Immediate Cause (Final disease or condition END STAGE Ho | ART DISEASE | | | Onset and Death MONTHS |
| المعدود | Medical Examiner | | resulting in death) Due to (or as a consequence of): | - 1 1 1 1 - | | | 1 |
| | | er | Sequentially list conditions, | GART FAILURE | | | MONTHS |
| | ed nsit | Examiner | cause Enter Underlying | LITERY DISEASE | C | | YEARS |
| | xecut n and al-tra | Еха | that initiated events resulting in death) Last c. Due to (or as a consequence of): | er every sisting | | | |
| 09 | ate be executed physician and the burial-transit | dical | L _d | | | | |
| 376 | ficate b g phys as the | Med | 550005 | | | | |
| c 687 | ath certifica attending p I for use as t | an/N | IF FEMALE: 23b. Was decedent pregnant 1 □ Live Birth 2 □ Fetal death 3 | ☐ Ectopic pregnancy | | 23d. Date of d | elivery |
| Вох | death | sici | 1 Yes 2 No | Other (specify) | | Month | Day Year |
| <u>P</u> .0 | at the | Physician/Me | g Unknown Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I | OO - Did tobo | | to the cause of death? |
| α <u>.</u> | requires that the der been signed by the a should be detached | Completed by | HYPERTENSION, TYPE I DIAK | | | 1.7 | Probably 4 Unknown |
| g | equir | etec | HYPERLIPIDEMIA, LUMBARS | O and Comment Comment | | | |
| Division of Vital Records, | The law ate has the | dm | | PINAL SIENOSIS, | 24a. Was an autopsy performe | prior to | utopsy findings available completion of cause of |
| œ — | ician: The certificate rector, pag | | PROSTATIC CARCINOMA 25. Was case referred to medical | 26. Place of Death (Chec | 1 🗆 Yes 2 | | es 2 No |
| /ita | iding Physician: T th. After this certifica funeral director, p | To Be | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati | | | c \ O41 (C | city) ASSISTED LIVING |
| of | a Phy er this ieral c | | 27. Manner of Death 28a. Date of injury 28b. Time | of 28c. Injury at | 28d. Describe how | | CITY) [13313 TEP E. VIIV |
| uo | I or Attending P s after death. I Director: After t d in by the funera | Certificate: | 1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation | work? M 1 ☐ Yes 2 ☐ No | | | |
| /ISI | r Atte | ertii | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify) | treet, factory, office | 28f. Location (Stre City or Town, S | et and Number or R | ural Route Number, |
| ò | pital or ours afte eral Dir filled in | | 1 | | | | |
|) | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi | Medical | 29a. Certifier (Check (Check 2 Medical Examiner: On the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investigation. | estigation, in my opinion, death occurred a | t the time, date and | place, and due to the | cause(s) and manner stated. |
| | ithin 2 the orthe | ž | only one) 3 Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier | ge, death occurred at the time, date and pl | | cause(s) and manner d. Date signed (Mon | |
| | F ≥ F 8 | | Amara () una | D 22832 | | 02/16/ | |
| J | X | | 30. Name and address of person who completed cause of death (Item 23a) (Type | | | | |
| | 13x,1 | | SOUN JA KIM, M.D. 5808 | MAIN STREET | , ELKRID | CE. Mi) | 21075 |
| | Stat | e | 31. Date filed (Month, Day, Year) 2012 32/Registrar's Signature FER 1 7 2012 | restal | | | |
| | Registra | ır | FED I (CUIL Cheener 10. 19 | CA CA CA | | | ` |

| ease | Type of Print in black indenble link. Linsure All Copi | 69 VIC |
|------|--|--------|
| | State of Maryland / Department of Health and Mental H | lvaien |

| | 1- For State Certific Registrar | cate of Death | Reg. No. | 2012 0465 |
|---|---|--|--|--|
| Physician/ | Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day | 3. Time of Death Year 1614 hrs |
| Medical Examiner | Falicia Annette Mock 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Deal | January 28, 2012 | ounty of Death |
| | 8105 New Hampshire Avenue # 5 | Hyattsville | | ce George's |
| Funeral Director | 5. Social Security Number 6. Sex 7. Age (In yrs. last b | irthday) If Under 1 Year If Under 24Hi Months Days Hours Mi Yrs. | | 7 9. Birthplace (State or Foreign Country) MN |
| • | Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow | Losstina | | 10d. Inside City Limits |
| Maryland 28a-f show any d at once. rector | MD Prince Georges Hy | vattsville | La | 1 Yes 2 No |
| or 28a- fied at | 10e. Street and Number | 10f. Zip Code 20783 | | USA |
| vith th | 8105 New Hampshire Ave #5 11. Marital Status 12. Was Decedent Ever in U.S. | 13. Was Decedent of Hispanic Origin? (| Specify Yes or No- 14. | Race - American Indian, Black, |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 37 is marked other than "matural", or items 23a or 28a-f also or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 XDivorced or Dates: | If Yes, specify Cuban, Mexican, Puerl | Spe | White, etc. ecity: Black |
| hours : | 15. Decedent's Education (Specify only highest grade completed) 16a | Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re | | of Business/Industry |
| 5-0036 ed within 72 hour other than "natu the Medical Exam Completed | Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs | Administrative | Mu | sic |
| 5-00 ed with tygiens other | 17. Father's Name (First, Middle, Last) | 18.Mother's Nam | ne (First, Middle, Maiden Surr | name) |
| 121(be fill be fill b | Orester Hollie | | ynne Joyce | |
| MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than aumatic event, the Medica To Be Comple | 19a. Informant's Name/Relationship (Type, Print) Nelwynne Hollie Mother | 9b. Mailing Address (Street and Number or 6100 Sargent Rd | | |
| e, M and 2 Health item 2 | 20a. Method of Disposition 20b. Place | e of Disposition (Name of cemetery, | | ation - City or Town, State |
| nord | | atory or other place) Lantic Crem 02 | /15/12 Gle | n Burnie MD |
| Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other tinjury or other traumatic event, the Medium of the | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility S | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do | ThomasAllenPA | | |
| Physician Medical | failure. List only one cause on each line. | nvolving Ethanol, Diphenhydramir | | Between Onset and |
| Examiner | or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | Treoretting Estation, Dipliciting district | o, Boxylammo, and r | |
| ner | Sequentially list conditions b. if any, leading to immediate cause. Enter Underlying Cause | | | |
| ted Insit Examiner | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. | | | |
| 760, cate be executed physician and he burial - transit | UNPENDED AMENDED | | | |
| 760, icate be physic the bur | IF FEMALE: 23c. If yes, outcome of pregnance 23c. If yes, outcome of pregnance 23c. If yes birth | C | | ate of delivery nth Day Year |
|). Box 687 the death certific oy the attending p ched for use as tr Physician/ | past 12 months? 4 Pregnant at time of death | 2 Fetal death 3 Ectopic pregr 5 Other (Specify) | iancy iwo | nui bay real |
| Bo ne deat the at red for | 1 Yes 2 V No 9 Unknown 9 Unknown | in the condensation across show to Dort I | 23a Did tahacca usa | contribute to the cause of death? |
| P.O. | | ing in the underlying cause given in Part I. | | o 3 Probably 4 Unknown |
| Records, : The law requires fificate has been sign, r, page 2 should be Completed | | | | 24b. Were autopsy findings available prior to completion of cause of |
| SCOF | | | autopsy performed? 1 ✓ Yes 2 No | death? 1 Yes 2 No |
| tal Recian: The certifical ector, pa | 25. Was case referred to medical | 26.Place of Death (Chec | | |
| F Vitz Physicia r this ce | 1 V Yes 2 No | · <u> </u> | • | 6 Other: Scene |
| Affe Affe | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: Pay, Year) FOUND: Jan 28, 2012 15 | b. Time of Injury DUND: 30 hrs 28c. Injury at Work? 1 Yes 2 ✓ No | 28d. Describe how injury of Subject took drugs | |
| Divisation A train Direct Ited in by efficient by entific | 3 ✓ Suicide 6 Could not be determined (Specify) Multi-Family A | farm, street, factory, office building, etc. pt. | or Town, State) | Number or Rural Route Number, City Avenue # 5, Hyattsville, MD |
| Division To the Hospital or Attentowithin 24 hours after death To the Funeral Director: completely filled in by the Medical Certificati | Check only one) 2 Wedical Examiner: On the best of my knowledge, one) 2 Wedical Examiner: On the basis of examination and/o | leath occurred at the time, date and place, an r investigation, in my opinion, death occurred | nd due to the cause(s) and m at the time, date and place, | nanner as stated. and due to the cause(s) |
| L M L S | 29h Signature and title of cartifier | 29c. License number | | e signed (Month, Day, Year) |
| | Victor Valler Vee | O.C.M.E. | Januar | ry 29, 2012 |
| Q | 30. Name and address of person who completed cause of death (Item 23a Victor Weedn MD JD Assistant Medical Examiner | 900 W. Baltimore Street, Baltim | ore, MD 21223 | |
| State | | | | |
| Registra | Josian Jo | fall | | |
| DHMH 17 Rev 1/2001 OCME 2006 | OCME | RIGÍNAL | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 23:03 Hugo Joseph Nyborg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Air 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Hours **Director** 215-32-7688 1 🔀 M 2 🗆 F 77 May 1, 1934 Maryland Usual Residence of Deced 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Joppa 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 104 Stone Harbor Ct. 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc. Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Automotive Elementary/Secondary (0-12) College (1-4 or 5+) 12 Electrician Manufacturer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F is marked Svante Emil Hugo Nyborg Marie Frances Pawlak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dora Nyborg / Wife 104 Stone Harbor Ct., Joppa, Maryland 21085 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2-15-2012 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland Rose Hill Services. 21. Signature of Juneral Service Licensee McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Presumes MYOCARDIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? The law requires Records, DIABOTES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 72011. CIE has autopsy performed? Yes 2 No death? Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deal To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 033 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Druin 5 NA-PhA Registrar's Signatu State Registrar

M80035

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

| | | Plea | se Type or | Print in | Black | k Indeli | ible Ink | . Ensure | e A | II Copies | s Ar | e Leg | ible. | | |
|--|------------------|---|--|---------------------------------------|------------------|--------------------------------|------------------------------|-------------------------|-------|---------------------------------|----------|-----------------------|---------------------------------|--|-------------|
| | | For | State o | f Marylar | | • | | | d M | lental Hy | gien | e 20 | 112 | 01.1 | 653 |
| | | State Registrar | (apt) | | (| Certifica | ate of D | eath | _ | | Reg. N | lo. 4 U | 1 6 | | |
| Physicia Medic | | 1. Decedent's Name (First, Middle, | OYE | | | | | | | 2. Date of Dea | |)av | Year 1 | 3. Time of | Peath M |
| Examin | | 4a. Facility Name (if not institution, | give street and num | ber) | | 4b. C | ity, Town, or | Location of De | ath | | 4 | c. County | of Death | | - |
| | М | 688 Paddle Whe | | | I4 6 5-45 - | r-) | Mill der 1 Year | lersvil | _ | 0.0 1 (5) | | Anne | e Aru | | |
| Funeral Director | | 570-56-0066 | 1 □ x M 2 □ F | 7. Age (<i>In yr</i> s. 68 | iast birtho | Month | | | lin. | 8. Date of Birt (Month, Day | y, Year) | | 9. Birthp | place (State or try) | Foreign |
| | | Usual Residence of Decedent | | | | | | | | May 20 | , 1 | 943 | | raska | |
| yland -f sho ed at | ctor | 10a. State 10b. County | | 10c. Ci | | or Location | | | | | | | 1 | 0d. Inside City | |
| r 28a notifi | Dire | Maryland Anne 10e. Street and Number | Arundel | | <u> </u> | liller | sville Zip Code | 9 | | | 10~ (| Citizen of V | VIII of Cour | 1 \(\text{Yes} | 2 X No |
| with th | Funeral Director | 688 Paddle Whe | el Court | West | | 101. | | 21108 | | | - | nite | | - | |
| eath v | Fune | 11. Marital Status | 12. Was Dece | dent Ever in U | .S. | 13. Was De | | | (Spe | cify Yes or No- Rican, etc.) | | | e - Americ | | |
| ifter d ", or i amin | by | 1 Never Married 2 🔀 Marri | Armed For 1 X Yes If Yes, Give | 2 No 19 | 02- | | s 2 No | | erto | rican, etc.) | | | k, White, e Whi | | |
| ours a stural | eted | 3 Widowed 4 Divorced | Year or Da | tes. 19 | | ecedent's U | | | | | 4.01 | | | | |
| 72 h an "na Medid | Completed | (Specify only highes | st grade completed) | 4 05 5 1) | (0 | | work done di | uring most of v | vorki | ng | 16b. | Kind of Bu | yland yland | | |
| withir giene er tha | | Elementary/Secondary (0-12) | College (1- | 4 Or 5+) | Cer | tifie | d Publ | ic Acc | oui | ntant | 5 | | - | ernment | : |
| e filed ttal Hy ed oth event | To Be | 17. Father's Name (First, Middle, La | | | | | | | | e (First, Middle, | Maidei | n Surname |) | | |
| uld bud by Mer marke | | Alfred Oscar Oyo | | | 1 | | | Fern | | | | | | | |
| 2 sho Ith an 27 is 'trau | | 19a. Informant's Name/Relationshi Nancy Evans Oye, | | | | | | | | West, | | | | | 1108 |
| 1 and if Hea item other | | 20a. Method of Disposition | | | Place of D | Disposition (/ | lame of | | | ary 15, | | Location - | | | |
| Page nent c ant: If ıry or | | 1 ☐ Burial 2 👿 Cremation 4 ☐ Donation 5 ☐ Other (Sp | | State | cemetery, We | crematory c est Ar Crema | undel | | 012 | | Ode | enton | , Mai | ryland | |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Funeral Service | sensee | | | | | s of Facility Funera | 1 1 | Home & | Cre | mator | y, P | .A. | |
| | | CARLES | K CEL | M013 | | 1411 | Annap | olis R | oac | l, Oden | ton | , Mar | ylan | d 21113 | |
| | | 23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final | | ch line. | | | Λ | | | | | | | Approximate Interval Betw Onset and De | /een |
| Physician/ Medical | | disease or condition resulting in death) | a. Due to (| or as a consec | | iy | FR | my | | DISE | ASE | | | Y DA | |
| Examiner | | | 540 10 (| 71 40 4 0011000 | Juli 100 01) | • | | | | | | | | | |
| _ # | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (| or as a consec | Juence of) | : | | | | | | | | | |
| executed an and rial-transi | xan | Cause (Disease or injury that initiated events resulting in death) Last | C. Due to / | or as a consec | uence of | | | | | | | | | | |
| be exe | I — I | resulting in death) Last | | or as a consec | derice oi, | | | | | | | | | | |
| icate g phys | 1edica | | d | | | | | | | | | | | | |
| ending | an/N | IF FEMALE; 23b. Was decedent pregnant | 23c. If yes, outo | ome of pregn | | 3 ☐ Ecton | ic pregnancy | , | | | | 23d. Dat | e of delive | ery | |
| requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit | by Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | ant at time of | | 5 Other | | , | | | | Moi | nth | Day Ye | ear |
| at the | , Ph | Part II. Other significant condition | ns contributing to de | eath but not re | sulting in | the underlyir | ng cause give | en in Part I. | | 23e. Did to | bacco | use contr | ibute to th | e cause of de | ath? |
| ires th signe | | | | | | | | | | | | | | ably 4 2 U | |
| v requ | Completed | | | | | | | | | 24a. Was a | an | | | osy findings av | |
| sician: The law of certificate has build lirector, page 2 s | omi | | | | | | | | | autop perfo | rmed? | | orior to cor leath? □ Yes | npletion of ca | use of |
| ian: T | Be C | 25. Was case referred to medical examiner? | | | | | 26. Pla | ce of Death (C | heck | _ | 2 423 1 | 101 | 163 | 2 110 | |
| hysic this ce al dire | 으 | 1 Yes 2. No | | npatient 2 | | | DOA Othe | r: 4 🗌 Nursin | g Ho | me 5 Resid | lence | 6 🗌 Othe | er (Specify) | | |
| ding F h. After t funer | Certificate: | 27. Manner of Death 1 Natural 5 Pending | | of injury h, Day, Year) | 28b. Tin inju | | 28c. Injury work? | | 2 | 28d. Describe h | ow inju | iry occurre | ed | | |
| Atten | rtific | 2 Accident Investigation 3 Suicide 6 Could not determine the suicide Could not determine the suicide could not be suicided. | ot be | of Injury - At h | ome, farm | | 1 | res 2 L NO | + | 28f. Location (S | treet a | nd Numbe | r or Rural | Route Numbe | er, |
| tal or safte al Dire | | 4 - Hornicide determin | buildir | g, etc. (Specif | (y) | | | | | City or Tow | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director. | Medical | (Check 2 L Medical Ex | Physician: To the be caminer: On the basi | s of examination | on and/or i | nvestigation, | in my opinio | n, death occurr | ed at | the time, date a | nd plac | e, and due | to the cau | ise(s) and man | ner stated. |
| o the ithin 2 the o the omple | Ň | only one) 3 L Certifying I | Nurse Practitioner: | To the best of | my knowle | | occurred at the 29c. License | | d pla | | | se(s) and mate signed | | | |
| F 8 F 0 | | Por i chaf | 172 | ten | 3 | 4 | | | 3 8 | | | | | | OLL |
| 16x1 | | 30. Name and address of person w | ho completed cause | of death (Iter | n 23a) (Ty | pe, Print) | \ / | | | wyAn | , 11 | 1000 | , iA A | 0 | , |
| Stat | · A | 31. Date filed (Month, Day, Year) | CALENT | A im | 41 | +5 | | NE | 7 | wyTr | NF | TPUL | J FVI (| 1140 |) |
| Registra | | FFR 1 7 2 | | a la | . 4 | arke | | | | | | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Eloise M. Oliver 8:20 P. M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A 3703 Everett Street Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Virginia Months Days Hours (Month Day Year) 28 216 24 9538 83 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location with the Maryland notified at 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 No Maryland Maryland 10e. Street and Number 10f, Zip Code ö 10g, Citizen of What Country? must be items 23a Funeral U.S. 21225 3703 Everett Street filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian the Medical Examiner Armed Forces? Black White etc. 6 \$ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify "natural", Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 6th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other မ Stuart Drumheller Margaret Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darla Stevens / Daughter Linthicum, Marvland 21090 460 Susan Court Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Mem. Park 02/20/2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) f Juneral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ OHENN disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death g | Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed?

Yes 2 No After this certificate 2 No 1 🗌 Yes 25. Was case referred to medical Be Hospital 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work' 1 🗌 Yes 2 🗌 No after death 2 Accident
3 Suicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

DHMH 17 Rev 7/2009

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRA-FULL BATELMD 46001

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

ie Hy

4600 Ritch

PMIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012

| | | - | For State of M. State Registrar | aryland / Depa <i>Cer</i> | artment of H tificate of D | | | giene Reg. No. 20 | 12 04655 |
|---|---|------------------|--|--|--|--------------------------------|--|--------------------------------------|--|
| | Physicia | in/ | 1. Decedent's Name (First, Middle, Last) | | | | 2. Date of Dea Month | th Day | 3. Time of Death |
| | Medic Examin | cal | David W. Pettis 4a. Facility Name (if not institution, give street and number) | Sr. | 4b. City, Town, or | Location of Death | | 6, 2012 4c. County of | BAM M |
| - | | | 2800 Michelle Road | | Manche | | | | arroll |
| | Funeral Director | | 5. Social Security Number 215-48-9638 Usual Residence of Decedent 6. Sex 1 X M 2 D F | e (In yrs. last birthday) 63 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Day Dec 6 | 1948 | 9. Birthplace (State or Foreign Country) Maryland |
| land | f show ed at | tor | 10a. State 10b. County | 10c. City, Town or Loc | cation | | | | 10d. Inside City Limits |
| Man Man | r 28a- notifie | Direc | Maryland Carroll 10e. Street and Number | Manches | ter 10f. Zip Code | | | 10g. Citizen of Wh | 1 Yes 2 No |
| with th | 23a o ıst be | Funeral Director | 2800 Michelle Road | | | 21102 | | US | |
| Z I Z I 3-0030 within 72 hours after death with the Maryland | f Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | þ | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent if Armed Forces? 1 Yes 2 If Yes, Give Year or Dates, | No | Vas Decedent of His FYes, specify Cubar ☐ Yes 2 🔀 No | | pecify Yes or No- p Rican, etc.) | | - American Indian, White, etc. white |
| 5-0050 | 'natur dical E | plete | 15. Decedent's Education (Specify only highest grade completed) | 16a. Deced | lent's Usual Occupa | ation | kina | 16b. Kind of Busi | |
| 1 7 1 | than he Me | Completed | Elementary/Secondary (0-12) College (1-4 or 5 | ife. DO | NOT use retired) | uning mode of wor | w.rg | st of | Maryland |
| 3 | al Hygie f other vent, t | Be | 17. Father's Name (First, Middle, Last) | 110 | | 18. Mother's Nar | me (First, Middle, | Maiden Surname) | rialytand |
| ylar F | and Mental I | 오 | Robert W Pettis | | | Cathe | | onna | Hammond |
| Name of the chord | Health and tem 27 is m | | 19a. Informant's Name/Relationship (Type, Print) Dorothy A Pettis spous | | ng Address (Street a Michelle | | | | |
| lore, | or other | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State | 20b. Place of Dispo- cemetery, crem | sition (Name of natory or other plac | e) | Date | 20c. Location - C | lity or Town, State |
| Baltimor | Department of Important: If it any injury or o | | 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice (See | Metro C | rematory . Name and Addres | Tnc: 2/1 | 7/2012 | Baltimor s Funera | e Maryland — l Home P.A. |
| מֹל | lmp any onc | | Muschell Stall | ind | 3111 Moi | untain Ro | oad Pasa | dena MD 2 | |
| | y inian Medical xaminer | | 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lind Immediate Cause (Final disease or condition resulting in death) a. Due to (or as | d the death Do not entered. | er the mode of dying | g, such as cardiac | or respiratory arr | est, | Approximate Interval Between Onset and Death 5 Mouth |
| cate be executed | physician and s the burial-transit | edical Examiner | cause. Enter Underlying Cause (Disease or Injury that initiated events | a consequence of): a consequence of): | | | | | |
| . Box ob/o | within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 Fetal death 3 [| Ectopic pregnanc Other (specify) | у | | 23d. Date Mont | of delivery h Day Year |
| IS, P.C. | n signed by uld be deta | ğ | Part II. Other significant conditions contributing to death t | out not resulting in the u | nderlying cause giv | ven in Part I. | | | oute to the cause of death? |
| Kecords, The law requires | ate has bee page 2 sho | Completed | | | | | 24a. Was autor perfo 1 \(\subsection Yes | printed? pri | ere autopsy findings available for to completion of cause of lath? □ Yes 2 No |
| VITAI | certific irector, | Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 I I I I I I I I I I I I I I I I I I | | Othe | ace of Death (Che | | | |
| OT V | erthis nerald | te: To | 27. Manner of Death 28a. Date of inju | | | 4 Nursing F | | dence 6 Other now injury occurred | |
| DIVISION Tal or Attendin | fter death. irector: Aft n by the fur | Certificate: | 2 Accident Investigation | ury - At home, farm, stre | M 1 🗆 | Yes 2 No | 28f. Location (\$ City or Tow | | or Rural Route Number, |
| Hosnital | 24 hours a Funeral D etely filled i | Medical C | 29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of entry one) 3 Certifying Nurse Practitioner: To the | examination and/or invest | tigation, in my opinio | on, death occurred | at the time, date a | ind place, and due t | to the cause(s) and manner stated. |
| To the | within To the compl | Z | 29b. Signature and title of certifier | Social injustation | 29c License | number 720 | 729 | 29d. Date signed | |
| | | | 30. Name and addless of person who completed cause of | death (Item 23a) (Type, F | Hanova | -A Pik | e Ma | ncheste | MD21102 |
| | Sta | ite | 31. Da E B (100m) 20 12") Lever 32. Regis | ar's Signature | | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 925A 201 Frances Mae Parsick Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL Rosedale Ballimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) **Director** 432-36-4720 1 □ M 2 🔀 F 11/27/1924 Arkansas Usual Residence of Decedent 87 or 28a-f show notified at with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No <u>Maryland Baltimore</u> Middle River ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be i Funeral <u>21 Longeron Drive</u> 21220 S. Α 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. ò 1 Never Married 2X Married Yes 2 No 5-0036 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working r than " 2121 life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene United States Government Certified Public Accountant other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic everonce. မ John Henry Willhite Elizabeth Sanders Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Joseph Parsick (Husband) 21 Longeron Drive Middle River, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burier 2 XCremation 3 Removal from State 2619 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland Signal re of born ral Se ce Lines 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 wurt 36a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or lead line. Approximate Immediate Cause (Final Onset and Death Ph. sician/ myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Cardiogenic Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HTIV 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? 2 🗌 No 1 🗌 Yes 2 - No Yes director. 25. Was case referred to medical Be B 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide the Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number City or Town, State) within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 3 🗆 (Check Certifying Nurse only one) petitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c, License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Danie!

31. Date filed (Month, Day,

faces

4000

INNETS

Presistrar's Signature

FRANKLIN SQUEGUEDR

Balto mal 21237

DHMH 17 Rev 06-201

| | | | Pleas | se Type or Pr | int in Black | Indelible I | nk. Ens | sure A | II Copie | s Are | e Legibl | e. |
|--------------------------------|---|-------------------|--|--|--|--|---------------|---|----------------------------------|-----------|-----------------|--|
| | | | For | State of M | laryland / De | - | | and M | 1ental Hy | /giene | 201 | 2 01.65 |
| | | | State Registrar | (4) | | ertificate or | Death | | | Reg. No | o. Z U I | 2 04657 |
| | Physicia | | Decedent's Name (First, Middle, Inc.) Through Marconson | , | | | | | 2. Date of De Month | | 12, 201 | 3. Time of Death 7:55 P M |
| 100 | Medic Examir | _ | Evelyn Margare 4a. Facility Name (if not institution, g | | | 4b. City, Town | or Location | of Death | repru | | c. County of D | |
| | LAGIIII | | Stella Maris H | Hospice | | Timon | | | | - 1 | Baltim | |
| 123 | Funeral | | | | ge (In yrs. last birthda | y) If Under 1 Yes Months Day | | r 24 Hrs. Min. | 8. Date of Bir (Month, Da | | | Birthplace (State or Foreign Country) |
| | Director | | 215-18-5085 Usual Residence of Decedent | 1 □ M 2 🔀 F | 89 Yrs | | | | | , | | aryland |
| | show dat | 후 | 10a. State 10b. County | - 3 | 10c. City, Town or | Location | | | | | | 10d. Inside City Limits |
| : | Mary 28a-1 otifie | irec | Maryland Harfor | -a | Bel Air | | | | | | | 1 ☐ Yes 2 🛂 No |
| : | th the | Funeral Director | 10e. Street and Number | | | 10f. Zip Code | | | | | itizen of What | Country? |
| : | ems 2 | nue | 200 Hazelnut C | 12. Was Decedent | | 21015 3. Was Decedent o | | rigin? (Spe | cifv Yes or No- | US | | nerican Indian, |
| 9 | ter de , or it amine | by | 1 Never Married 2 Marrie | | No | 3. Was Decedent of If Yes, specify Cu | | | Rican, etc.) | | Black, W | |
| 000 | within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at | Completed | 3 ▼ Widowed 4 □ Divorced | If Yes, Give Year or Dates. | | 1 Yes 2 X | | /: | | | Specify: V | Mhite |
| 5 | n "na Nedic | agu. | 15. Decedent' (Specify only highest | grade completed) | (Gi | cedent's Usual Occ ve kind of work don . DO NOT use retire | e during mo: | st of worki | ng | 16b. k | Kind of Busines | ss/Industry |
| 212 | within giene. er tha er the | S | Elementary/Secondary (0-12) | College (1-4 or | 0+) | emaker |) | | | 0 | wn Home | 2 |
| nd | tal Hyg | To Be | 17. Father's Name (First, Middle, Las | | | | | | (First, Middle | , | | |
| Z a | should be and Men is marke aumatic | - | John Joseph Bur | | | | | | | | th Slee | |
| Baltimore, Maryland 21215-0036 | I and z should be lied within /2 hours after death with the Maryland of Health and Mental Hygiene. I then the marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at | | 19a. Informant's Name/Relationship Kathleen Ward / | | | ailing Address (Stre 23 Grande | | | | | | |
| e, | other | | 20a. Method of Disposition | | 20b. Place of Dis | sposition (Name of | - 1 | | Date | | | or Town, State |
| im [| permit. Page 1 a Department of H Important: If ite any injury or ot once. | | 1 → Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp | | | rematory or other p | | 2-15 | -2012 | Ba: | ltimore | , Maryland |
| 3alt | Pepartit Pep | | 21. Signature of Funeral Service Lic | Sisge N . | 1 | 22. Name and Add | | | | | | • |
| | 00260 | \dashv | 23a. Part 1. Enter the disease, or co | | d the death Decat | | | | | <u> </u> | n, Mary | land 21009 |
| D | hysician/ | | shock, or heart failure. List onl | y one cause on each lin | | | ying, such as | s cardiac o | r respiratory ar | rrest, | | Approximate Interval Between Onset and Death |
| | Medical | | disease or condition resulting in death) | | IMER'S DIS | SEASE | | | | | | |
| | Examiner | | Sequentially list conditions | h — | | | | | | | | |
| 7 | i ii | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as | a consequence of): | | | | | | | |
| ** | ian and urial-transit | Exar | Cause (Disease or injury that initiated events resulting in death) Last | c Due to (or as | a consequence of): | | | | | | | |
| U | /sician | | | d | | | | | | | | |
| 68760 certificate be | ng ph) | Med | IF FEMALE: | | | | | | | | | |
| × 4 | ttendir or use | ian/ | 23b. Was decedent pregnant in the past 12 months? | | 2 Fetal death | | | | | | 23d. Date of | , |
| Box | signed by the attending physici d be detached for use as the bu | Physician/Medical | 1 Yes 2 X No 9 Unknown | 4 ☐ Pregnant a 9 ☐ Unknown | t time of death | Other (specify) | | | | | Month | Day Year |
| Records, P.O. | ned by | by P | Part II. Other significant conditions | s contributing to death b | out not resulting in th | e underlying cause | given in Part | 1. | 23e. Did t | obacco i | use contribute | to the cause of death? |
| dS, | been sign | ed b | | | | | | | 1 🗆 | Yes 2 | X No 3□ | Probably 4 🗆 Unknown |
| Records, | as been 2 shoult | Completed | | | | | | | 24a. Was auto | | | autopsy findings available o completion of cause of |
| Be l | nis certificate has b | | | | | | | | perfo | ormed? | death' | |
| ital | certifii | m | 25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No | Hospital: | | | Place of Dea | | | | 25 | |
| of Vital | er this | e: 1 | 27. Manner of Death | 28a. Date of inju | ent 2 ER/Outpat ry 28b. Time | of 28c. Ini | 4 LI N | | ne 5 Resident | | | ecify) HOSPICE |
| on on | eath. or: After he funer | Ficat | 1 X Natural 5 Pending 2 Accident Investigat | | y, Year) injun | | ork? Yes 2 | | | , | | |
| Division alor Attendin | after death. Director: A in by the fu | Certificate: | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine | | ury - At home, farm, : c. (Specify) | street, factory, office | 9 | 1 | 28f. Location (\$ City or Tox | | | Rural Route Number, |
| Division of Vital | within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | cal | 29a. Certifier 1 Certifying P | hysician: To the best of | my knowledge desi | h approved at the t | | 1 - 10 | | | | -4-4-1 |
| e Hos | within 24 hours To the Funeral completely filled | Medical | (Check 2 L Medical Exa | miner: On the basis of e urse Practitioner: To th | xamination and/or inv | estigation, in my opi | nion, death o | ccurred at | the time date a | and place | and due to th | e cause(s) and manner stated |
| 년 # | within To the compl | | 29b. Signature and the of certifier | | | | nse number | ato and pla | 50, 4110 000 101 | | te signed (Mor | |
| | | | 14 Stalls | 2 CANT | | BI | 4979 | 12 | | 21 | 13/201 | 2_ |
| | 3 | [| / (| o completed cause of d | | | | A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | 1000 | | |
| | Stat | e 3 | JACKIE JÖNES, 31. Date filed (Month, Day, Year) | | DULANEY V | | TLM | ONTU | 1, MD 2 | 1093 | 5 | |
| | Registra | | FER 1 7 2 | 012 Dem | N B. A | arke | | | | | | |
| DHME | 1 17 Rev 06-2 | 011 | | 100 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 14, 2012 3:00 A M THOMAS LEONARD PAPE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min Director 214-30-9606 1 XM 2 🗆 F 79 Feb. 16, 1932 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No |Maryland | Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral USA 20 Porter Drive 21009 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify "natural" Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and 2 should be filed within 7/8 Health and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Drywall Company 12 Contractor Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Eleanor Louise Niner John Dedrick Pape 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Porter Drive, Abingdon, MD 21009 Lavonne D. Pape / Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fallston, Maryland Highview Memorial Gdn 2-17-2012 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 mas 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ Nespenti. disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Bacterer Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by COPD 1 Yes 2 No 3 Probably 4 Unknown Completed esaplace of come 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospita Other: 1 Yes 2 000 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Director: After 5 Pending 1 Natural M Accident Investigation filled in by the 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

10

Maryland 21215-0036

Baltimore,

68760

P.O.

Records,

of Vital

Division

State Registrar 29b. Signature and title of certifier

DAVID DUNN 31. Date filed (Month, Day, Year) 615 W. MACPHAIL ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

033255

BEL AIR, MD.

29d. Date signed (Month, Day, Year)

Palme

21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 14, 2012 Physician/ Lilawati M. Patel 01:06 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center - Howard County Columbia Howard 6. Sex **Funeral** Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months 1 □ M 2 X December 4, 1928 Hours **Director** 120-66-4417 83 India Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Director Maryland Howard 1 Yes 2 X No Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12910 Wexford Park 21029 United Kingdom 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No Completed by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: Asian Indian 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Shanabhai Patel Chanchalben Patel and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 is Department of Health Important: If item 27 any injury or other th once, Bharat Patel/Son 12910 Wexford Park, Clarksville, Maryland 21029 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 West Arundel Crematory February 17, 2012 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will E Boun M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phairian Head and Neck Squamous Cell disease or condition Carcinoma years) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events One to for as a consection of or the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Month Pregnant at time of death Day Year be detached 1 ☐ Yes ∠ ¥ Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ovarian Records, 1 Yes 2 No 3 Probably 4 Nonknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.3 page 2 performed' 2 🗆 No Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 101 29d. Date signed (Month, Day, Year) D006063L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

BINDU

31. Date filed (Month, Day, Year)

FEB 1

COLUMBIA

CEDAR LANE

Registrar's Signature

6336

JOSEPH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | For State Registr <i>a</i> r | State of Maryland / [| Department of Heal Certificate of Dea | | ntal Hygiene Reg. No. | 0010 | 01,660 |
|----------------------------|--|-------------------|---|--|--|--|--|--|--|
| | | | Decedent's Name (First, Middle, La | est) | | 2.1 | Date of Death | L. C. I ha | 3. Time of Death |
| - | Physici /Medic | | Martha Eller | | | Fe | Month Day | 1012 | 6:10 PM |
| and See | Examin | er | 4a. Facility Name (If not institution, give | re street and number) | 4b. City, Town, or Loca | . 1 | | County of Death | |
| | Funeral | | 5. Social Security Number 6. S | Sex 7. Age (In yrs. last bir | thday) If Under 1 Year If Under 1 Year Months Days Ho | nder 24 Hrs. 8. I | Date of Birth (Month, Day, Year) | 9. Birthp Cour | |
| | Director | | 2/3-/6-5883 Usual Residence of Decedent | , , , | |) Se | pt. 17, 15 | 919 Mai | yland |
| | aryland show | <u>-</u> | 10a. State 10b. County | 10c. City, Town | | | | 1 | 0d. Inside City Limits 1 Xes 2 □ No |
| | the M | Director | Maryland N/A 10e. Street and Number | Delt | 10f. Zip Code | | 10g. Cit | tizen of What Cour | |
| | h with 23a ou | | 3126 WINSON | Arenne | 2/2/6 | | Un | tel St | when I |
| | tems tems | Funeral | 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispani If Yes, specify Cuban, Me | ic Origin? (Specify exican, Puerto Rica | Yes or No- en, etc.) | 14. Race - Americ Black, White, | |
| 980 | be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, If a Medical Examinar ment be indiffied at | þ | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ∐Yes 2 1 No If Yes, Give Year or Dates: | 1 □Yes 2 ANO Spe | ecify: | | Specify: Bla | ck |
| 5-0 | 72 ho "natur | eted | 15. Decedent's E (Specify only highest gr | | Decedent's Usual Occupation (Give kind of work done during | most of working | 16b. K | ind of Business/Inc | |
| 21215-0036 | within liene. | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | Beautician | | 5 | alan | |
| | be filed value Hygis | Be C | 17. Father's Name (First, Middle, Last | 1 | | Mother's Name (Fi | rst, Middle, Maiden | Surname) | |
| Maryland | thould be nd Mental marked o matic eve | မ | 100 laterweeth News (Polationship | <u> </u> | . Mailing Address (Street and N | -lora | Downs | or Town State 7in | Cadal |
| Ma | nd 2 saith ar 27 is rrau | | 19a. Informant's Name/Relationship | 6 0 | A . | Augus | Balto, | | 12.15 |
| ore, | ges 1 au t of Hea lfitem or othe | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | ZOD. Flace of | Disposition (Name of Pry, crematory or other place) | Date | | ocation - City or To | own, State |
| Baltimore, | t. Pages tment of tant; If its ijury or o | | 4 Donation 5 Dother (Speci | (y) Urbut | hus Mam. Park | Fe5,23 | 2012 13 | altimor | e MD |
| Bal | permit. Page: Department of Important; If any injury or once. | | 21. Sign fure of Funeral Service Lice | du (| 22 Name and Address of F CACUINAL W 5913 Poblate | Facility Viciliams Vale Rd. | FS., P.A. Balto; | MD 212 | -28 |
| | | | shock, or heart failure. List only | oplications that caused the death. Do one cause on each line. | | ch as cardiac or re | spiratory arrest, | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. Due to (or as a consequence | ENSON | | | | |
| | Examiner | | Sequentially list conditions. | b. DIATERIT | ES ME11 | 11/5 | | | ANK |
| | uted I Insit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequence | Oil HBA | TO DU | LF 160 | | UNK |
| oʻ | e exectian and | | resulting in death) Last | Due to (or as a consequence | of): | | 116017 | | |
| 68760, | eath certificate be executed attending physician and for use as the burial-transit | dical | | d | _/ | | | | |
| Box 6 | n certif ending use as | | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregnancy | 0 T 5 th all and a second | | ļ | 23d. Date of delive | ery |
| O. B | law requires that the death certit as been signed by the attending 2 should be detached for use as | Physician/M | in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | | Month | Day Year |
| σ. | ires that the de signed by the a d be detached | by Phy | | contributing to death but not resulting in | n the underlying cause given in F | Part I. | 23e. Did tobacco | use contribute to t | he cause of death? |
| Division of Vital Records, | w requires been sig should be | ted b | | | | l | 1 ☐ Yes 2 | No 3□ Prol | oably 4 ☐ Unknown |
| 3ec | e law r has be ge 2 sh | Completed | | | | | 24a. Was an autopsy performed? | 24b. Were auto prior to co death? | ppsy findings available mpletion of cause of |
| tal | an: The tificate h or, page | | 25. Was case referred to medical | | 26 | Place of Death (C | 1 □Yes 2 🗹 No | 1 ☐ Yes | 2 □ No |
| ί | Physician: r this certific ral director, I | o Be | examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou | _ Other: | _ / | 5 Residence | 6 ☐ Other (Special | fy) |
| o u | ding Physician: The In. After this certificate hit funeral director, page | [:uo | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | | Fime of 28c. Injury at mjury Work? | | Describe how injur | ry occurred | |
| isio | Attend r death ctor: , y the f | ficat | 2 Accident investigatio 3 Suicide 6 Could not be determined | e 290 Place of Injury. At home fa | M 1 ☐ Yes | | Location (Street ar | | al Route Number, |
| 5 | ital or ars after ral Dire | Certification: To | 4 I Hornicide | | | | City or Town, State | | |
| | To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funera | Medical | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa | hysician: To the best of my knowledge miner: On the basis of examination ar and manner stated. | e, death occurred at the time, da d/or investigation, in my opinion | ate and place, and n, death occurred a | due to the cause(s at the time, date an | s) and manner as s d place, and due t | stated. o the cause(s) |
| | To th withir To th comp | Me | 29b. Signature and title of certifier | | 29c. License num | nber | 29d. Da | ate signed (Month, | Day, Year) |
| | | | · Cury & | | 1004 | 17096 | | 2,19 | ,2012 |
| | n . | | 30. Name and address of person ho | completed cause of death (Item 23a) | (Type, Print) | - Almi | | 2 N | |
| | 81 | | KRNNGIH / 1 | INDUBLES M | 1) 119 GA | 71 14121 | 076 | (LNC | 1 (More |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day February Physician/ 8:30 DWIGHT, L POAG 21/12 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ceci Point Perry VA MARY LAND HEALTH CARE SYSTEM 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location with the Maryland Completed by Funeral Director 1 🗌 Yes 2 🗷 No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21902 ed other than "natural", or items event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 If Yes, Give Year or Dates. 1 ☑ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden St M. ပ is marked JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trai 011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2 Cremation 3 Removal from State 1 🔲 Burial 4 Donato 5 Other (Specific of Facilit Part 1. Enter the disease or complications that caused shock, or beart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator Approximate Interval Between Onset and Death immediate Cause (Final disease or condition Physician/ HUMAN IMMUNDARTICIENCY Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Dualty for as a persecuence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4 Pregnant : Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whitnown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 1 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DDA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Matural 5 Pending 1 Tes 2 No n 24 hours after death.

Ne Funeral Director: A pleted filled in by the fu Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 **To the** I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier o 14,2012 D42800 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Q. VA MARYLAND HEALTH CARE SYSTEM PERRY Point, MD 21902 Thomas Biondo 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04662 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ Day 7: 30 P_M Maggie M. Quille 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Future Care Irvington Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Yea B - 5 - 1912 215-05-9557 **Director** 1 □ M 2 🗶 F Ă1 99 Usual Residence of Decedent shov or 28a-f shov notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director N/A MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zio Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 2022 S. Athol Street 21229 USA permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene.
Important: if item 27 is marked Albert. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: Black Completed 3 ₩Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 2 12th yrs. LPN Various Employers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fred Brown Magnolia Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah E. Montgomery-Sister 3112 Elbert St. Baltimore, MD 21229 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Danation 5 Other (Specify) Baltimore National 2/16/2012 Baltimore, MD 22. Name and Address of Facility March F/H East 1101 E. ignatu of Funeral Service License North Ave. Baltimore, MD 21202 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Imr e ate Cause (Final di eare or condition Onset and Death Physician/ ASCV Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed autopsy 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. I Director: After the 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural work? 1 ☐ Yes 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

3 29b. Signature and title of certifier

Trun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR . HZRA H NME (& Z | N . Ecultary

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

| | | | Plea | | | | | | | | | | All Copie | | _ | ible. | |
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| | | For State | | | State o | of Ma | rylan | | | | | and N | /lental Hy | _ | 20 | 12 | 04663 |
| | | Registrar 1. Decedent's Name | e (First, Middle | e, Last) | | | | | ertifica | te of L | <i>Jeatn</i> | | 2. Date of D | Reg. N | lo. 4 U | 1 6- | 3. Time of Death |
| Physicia Medic | | LARRY | | BER | RNARD | | QU | EEN | | | | | Month FEBRU | | 13 | Year 2012 | |
| Examin | | 4a. Facility Name (if | | | | | | | | ty, Town, or | | | | | c. County | | |
| Funeral | | 1001 (5. Social Security No | CYPRESS umber | 6. Sex | E DRI | | In yrs. la | ast birthday | _ | APITO. der 1 Year | | CGHTS r 24 Hrs. | 8. Date of B | | RINCE | | DRGE 'S |
| Director | | 577-63-8 | 3923 | 1 X | M 2 □ F | | 64 | Yrs. | Month | s Days | Hours | Min. | (Month, D APRIL | av. Year) | 1947 | Coun | |
| ind show at | 5 | Usual Residence of 10a. State | Decedent 10b. County | | | T | 10c. Cit | y, Town or l | ocation | | | | | | | 1 | Od. Inside City Limits |
| Maryla 28a-f s otified | rect | MD | PRINCE | E GEO | RGE'S | | CAP | ITOL | HEIG | HTS | | | | | | | 1 X Yes 2 ☐ No |
| th the | Funeral Director | 10e. Street and Nun | | | | | | | | Zip Code | | | | | Citizen of W | /hat Cour | ntry? |
| ath wi | nue | 1001 CYI | PRESS 1 | | DRIVE . Was Dece | | er in U.S | S. 13 | | 20743 edent of Hi | spanic O | riain? (Spe | ecify Yes or No | US - | | - Americ | can Indian, |
| fter de , or it amine | by | 1 🔀 Never Marri | | | Armed For 1 Yes If Yes, Give | 2 X N | 0 | | If Yes, sp | ecify Cuba | n, Mexica | n, Puerto | Rican, etc.) | | Black | k, White, | etc. |
| ours a atural' cal Ex | eted | 3 🗌 Widowed | 4 Divorced | | Year or Da | | | 160 Dag | | sual Occup | | /. | | 1 | Specify: | | ACK |
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| d withi | Be Co | 12 | 2th | | | | | CO | NSTR | JCTIO | | | | | RIVAT | | |
| be file ental F ked of | To B | 17. Father's Name (I | | | | | | | | | | | e (First, Middle COAT) | | n S <i>ur</i> na <i>m</i> e, |) | |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 19a. Informant's Na | ame/Relations | hip <i>(Typ</i> e, | | | | 19b. Ma | iling Addre | ess (Street a | | | al Route Numb | | or Town, St | tate, Zip (| Code) |
| lealth im 27 im 27 her tra | | ANTHONY | | BROT | HER | | | | | | E DRI | IVE J | ACKSON | 1 | | | |
| age 1 ant of H | | 20a. Method of Disp | ☑ Cremation | 3 □ Re | moval from | State | С | Place of Dispermetery, cr | ematory o | r other plac | | | Date | | Location - | | |
| mit. Pa bartme bortan r injury | | 4 ☐ Donation 21. Signature of Fur | | | Δ | 1 | KI | VERDAI | | | | | /2012 B. JEN | | | | ARYLAND HOME, INC. |
| permi Depai Impo any ir | | ▶ Wapt | mey | N. | Cor | nel | W. | \cup | 7474 | LAND | OVER | ROAI | D HYATT | SVII | | | AND 20785 |
| | | 23a. Part 1. Enter t shock, or hear Immediate Cause (| | r complica only one o | ations that c cause on ea | aused tl ch line. | he deat | h. Do not er | nter the m | ode of dyin | g, such as | s cardiac o | or respiratory a | arrest, | | | Approximate Interval Between Onset and Death |
| Physician/ , Medical | | disease or condition resulting in death) | | a. | | | | NEY D | ISEAS | E | | | | | | | Onoot and Dodg. |
| Examiner | _ | Sequentially list co | nditions | b. | HYPE | | | | | | | | | | | | |
| ed sit | Examiner | if any, leading to im cause, Enter Under Cause (Disease or | nmediate rlying | 2 | | | | uence of): | | T TIMEON | T A TO 37 | DTCE | A CE | | | | |
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| te be e nysicia ne buri | dical | | | C d. | | | | | | | | | | | | | |
| ertifica ding ph | /Me | IF FEMALE: | | 230 | . If ves, out | come of | pregna | ncv | | | | | | | | | |
| eath o | by Physician/Medica | 23b. Was decedent in the past 12 r 1 \(\sum \) Yes 2 | months? | | 1 Live I 4 Pregr | Birth 2 nant at t | Feta | al death 3 | ☐ Ectop☐ Other | c pregnanc (specify) | У | | | | 23d. Date Mor | | ery Day Year |
| t the d by the | Phys | 9 🗌 Unknown | | | 9 Unkn | | | ulation of the above | or alastica | | i- D | | | | | | |
| res tha signed | d by | Part II. Other signif | icani conditi | ons contr | ibuting to de | eath but | notres | uiting in the | underiyii | g cause gn | ren in Par | · 1. | | | | | bably 4 Unknown |
| v requi | Completed | | | | | | | | | | | | 24a. Was | | 24b. V | Vere auto | psy findings available |
| The lav te has page 2 | omb | | | | | | | | | | | | auto per 1 \square Yes | opsy formed? | d | rior to co leath? | mpletion of cause of |
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| Physi r this c eral dir | e: To | 1 XYes 2 2 27. Manner of Death | | | 1 28a. Date | of injury | | ER/Outpati 28b. Time | | DOA Othe | 4 L N | | ome 5 X Res 28d. Describe | | | |) |
| ending eath. or: Afte he fund | Certificate: | 1 X Natural 2 Accident | 5 Pendii | gation | (Mont | th, Day, | Year) | injury | M | work | | | | , | , | | |
| or Atta | Certi | 3 ∐ Suicide 4 ☐ Homicide | 6 ∐ Could detern | | 28e. Place buildir | of Injury ng, etc. (| | | treet, fact | ory, office | | | 28f. Location City or To | | | r or Rural | Route Number, |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director. | edical | 29a. Certifier 1 | Certifying | g Physicia | an: To the b | est of m | y knowl | edge, deatl | occured | at the time, | , date and | l place, an | nd due to the c | ause(s) a | and manne | r as state | ed. |
| the Ho nin 24 l the Fu | Med | only one) 3 | ☐ Certifying | Nurse P | : On the bas ractioner: | is of exa | mination est of my | n and/or inve y knowledge | estigation, , death oc | in my opinic curred at the | en, death on, da | occurred at te and plac | t the time, date ce, and due to t | and place he cause | ce, and due e(s) and mai | to the car nner as st | use(s) and manner stated ated. |
| P S S S | | 29b. Signature and | title of certifie | | | f | | | 2 | gc. License | | | | | ate signed | | |
| Uly | | 30. Name and addre | ess of person | Who com | pleted caus | e of dea | th (Item |) 23a) (Type | Print) | | 5539 | | | | | | 5, 2012 |
| - \ V | | EUGENE | TAYLOR | II | MD 14 | 58 A | DDI | SON R | OAĎ S | SOUTH | CAPI | TOL | HEIGHT | S,MA | RYLAN | ID 20 | 743 |
| Stat Registra | | FEB1172 | 012 Year) | even | 32. R | gistrar's | Signat | ture | | | | | | | | | |

DHMH 17 Rev 7/2009

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| | | | For State of M | aryland / Depa | rtment of Healt <i>tificate of Deatl</i> | h and Mental Hy h | giene 2012 | 04664 |
|----------------|---|--------------------------|--|--|---|--|---------------------------------------|--|
| | | | 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) | Cert | meate of Death | 2. Date of De | | 3. Time of Death |
| | Physicia Medic | | John Frederic Requardt J | r. | | Februa: | cy 10 2012 | 12:05 A ^M |
| | Examin | | 4a. Facility Name (if not institution, give street and number) | | 4b. City, Town, or Location | on of Death | 4c. County of Dea | th |
| | | | William Hill Manor 5. Social Security Number 6. Sex 7. Ag | e (In yrs. last birthday) | Easton If Under 1 Year I If Und | der 24 Hrs. 8. Date of Bir | Talbot | thplace (State or Foreign |
| | Funeral Director | | | 92 Yrs. | Months Days Hour | | ny, Year) Co 1920 Ma | aryland |
| | and show | ě | 10a. State 10b. County | 10c. City, Town or Loca | ation | | | 10d. Inside City Limits |
| | Maryla 28a-f | rect | MD Talbot | Trappe | | | | 1 🗆 Yes 🏞 No |
| | with the 23a or 3 | Funeral Director | 10e. Street and Number 3745 Koogler Rd. | - | 10f. Zip Code 21673 | | 10g. Citizen of What Co USA | ountry? |
| 0 | er death or items miner m | by Fun | 11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent I Armed Forces? 1 ☑ Yes 2 □ | No 1943- | Yes, specify Cuban, Mexi | | Black, Whit | e, etc. |
| 213-0030 | urs aft tural", al Exa | | 3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates. | 1945 | ☐ Yes 2 🗓 No Spec | cify: | Specify: wh: | rte |
| <u></u> | 72 ho n "nat fedica | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give ki | ent's Usual Occupation ind of work done during m NOT use retired) | nost of working | 16b. Kind of Business | Industry |
| 7 | within giene. er tha the N | | Elementary/Seconday (0-12) College (1-4 or 9 0 | 0+) | orer | | construc | ction |
| 2 | filed tal Hyg | To Be | 17. Father's Name (First, Middle, Last) | | | other's Name (First, Middle, | | |
| yland | uld be I Ment narke natic | ۲ | John Frederic Requardt | | | Margaret Caro | - | |
| , Mai | od 2 sholealth and nc n 27 is r | | 19a. Informant's Name/Relationship (Type, Print) Wendy Requardt – daughte | | | mber or Rural Route Number d; Trappe, MI | | p Code) |
| baltimore, | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🔀 Donation 5 ☐ Other (Specify) | 20b. Place of Dispos cemetery, crema | ition (Name of atory or other place) | Date | 20c. Location - City or | Town, State |
| מ | permit. Departn Imports any inju | | 21. Signature Funeral Service Length of Fune | eter 22. | | cility State Ana | - | 21201 |
| ı | | | 23a. Par 1. Enter the disease, or complications that caused shoot, or heart failure. List only one cause on each line | the death. Do not enter | the mode of dying, such | as cardiac or respiratory a | rest, | Approximate Interval Between |
| - F | 'thyreician/ | | Immediate Cause (Final disease or condition | CVA - 436 | 0 | | | Onset and Death |
| | Medical Examiner | | | a consequence of): | a. t | | | years |
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| | uted d ansit | amir | cause. Enter Underlying Cause (Disease or linjury that initiated events c | | | _ | | |
| | e exec ian an urial-tr | edical Examiner | resulting in death) Last Due to (or as | a consequence of): | | | | |
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| 000 | certific ding partitions is as | | IF FEMALE: 23c. If yes, outcome | of pregnancy | | | 23d. Date of de | alivery |
| DOX | the atter | Completed by Physician/M | in the past 12 morths? 1 ☐ Yes 2 ☐ No | 2 Fetal death 3 Lat time of death 5 Lat | Ectopic pregnancy Other (specify) | | Month | Day Year |
| | that th | y Ph | Part II. Other significant conditions contributing to death b | out not resulting in the un | derlying cause given in P | Part I. 23e. Did t | tobacco use contribute to | o the cause of death? |
| us, | quires en sign | ed b | | | | 1 🗆 | Yes 2 No 3 F | robably 4 🗆 Unknown |
| Vital Records, | e law rec e has ber ge 2 sho | mple | | | | 24a. Was auto perfe | psy prior to death? | utopsy findings available completion of cause of |
| <u> </u> | an: Th tificate tor, pa | Be Co | 25. Was case referred to dical | | 26. Place of D | ☐ 1 ☐ Yes Deat heck only one) | 2 No 1 ☐ Ye | s 2 No |
| <u> </u> | hysici nis cer I direc | P P | examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpat | ient 2 ER/Outpatient | 3 DOA Other: 4 | Nursing Home 5 - Resi | dence 6 🗆 Other (Spec | cify) |
| 0 U | nding Pł ath. :: After tł e funeral | | 27. Manny of Death 1 V Natural 5 Pending 2 Accident Investigation | | 28c. Injury at work? M 1 🗌 Yes 2 | | how injury occurred | |
| DIVISION | lor Atte after de Directo | Certificate: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inj building, et | ury - At home, farm, stree c. (Specify) | et, factory, office | 28f. Location (City or To | Street and Number or Ru wn, State) | ıral Route Number, |
| _ | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit. | Medical | 29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e only one) Certifying Nurse Practioner: To the | examination and/or investi | gation, in my opinion, deat | h occurred at the time, date | and place, and due to the | cause(s) and manner stated. |
| | To the within To the comp | 2 | 29b. Signature and/little of certailer | | 29c. License number | | 29d. Date signed (Mont | |
| | | | 1 / An JA /// | 1 | DU0704 | 05 | 2/10/ | 2012 |
| | | | 30. Name and address of person who completed cause of o | | | | | |
| | Sta | to | Curtis Matthew Foy 5. 31. Date filed (Month, Day, Year) 22. Registr | ar's Signature | r. Easton,M | D 21601 | | |
| | Registra | | FEB 1 7 2012 Senesa | ar's Signature | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month -ED Physician/ 2-35PM Medical wn, or Location of Death 4c. County of Death Name (if not institution, give street and number, Examiner Massachuse++ Himore If Under 1 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months **Director** 1 🗆 M 2 💢 F 72 1939 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ms 23a or 28a-f shormust be notified at **Funeral Director** 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA gssachusettes items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Be Completed by 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced and Mental Hygiene.

I is marked other than "natur."

I is marked other than "natur." 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired College (1-4 or 5+) Elementary/Secondary (0-12) Domestic Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Whi Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trai once. Baltimore, MD West Hill Rdi 5000 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 7/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licensee 1101 E. North Are Baltimore 13 rom 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Onset and Death Immediate Cause (Final tension Physician/ disease or condition Medical resulting in death) **Examiner** SIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 attending p IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Dav Year Yes 2 No Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? SKOUN autopsy perform 2 🗆 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 4 Nursing Home A Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer injury 1 Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier NACOUN Feh 19/19/1 who completed cause of death (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 Runk, Clayton Edward Medical 4a. Facility Name (if not institution, give street and number, County of Death **Examiner** ranklinSquare 2OH 0 If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months 216-34-9998 74 Director 1 🙀 M 2 🗆 F Aug12,1937 or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Dundalk Baltimore Md . 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral U.S.A. 21222 103 Center Place, Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc 1X Never Married 2 Married þ Run K, Clay tor Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Sparrows Point and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Ship Yard Machinist 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. မ Marie Margaret Kolb Clayton Edward Runk, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2910 Delmar Avenue Baltimore, Md. 21219 Robert Runk / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 14,2012 Baltimore, Maryland Moreland Memorial 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. M0093321. Signature of Funeral Service Licensee dwl 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir ho attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Pregnant signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? 2 🗖 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 5 Pending Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and icense number 29d. Date signed (Month, Day, Year)

> ss of person who completed cause of death (Item 23a) (Type, Print) John,

Sebastian K.

31. Date filed (Month, Day, Year, FEB 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Birthplace (State or Foreign Country)

10d. Inside City Limits

Interval Between

Year

Month

1 Yes 2 No

12012

1 ☐ Yes 2X No

Maryland

White

State

Registrar DHMH 17 Rev 06-2011 M.D.

100551

3023 Eastern Avenue Baltimore, Md.21224

Please Type or Print in Black Indelible link, Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** EAL 10 LBE /Medical 4a Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner 82765 SALTIMOREL. 1eDicareacy r If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Country) Maryland 78-1279 1 M 2 F Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shot any injury or other traumatic event, the Medical Examiner mast be notified at 1∏ Yes 2 □ No Directo MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1419 N. Central Ave. 21202 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: black Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elbert Sylvaneus Teal Sr. Seccola Jones ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Davis - brother 1419 N. Central Ave; Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Check (Specify) In State 2/26/2012 Hanover, MD Ardent Cremation 21. Signature of Funeral Service Licensee Director 22. Name a Phillip Weatherford 2431 E. Baltimore, MD 21213 Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** illingical Immediate Cause (Final 18405-5 disease or condition resulting in death) SOCK Examiner Due to (or as a consequence of) Examiner THORACPH -esis attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760 SIBLE Physician/Medicai that initiated events resulting in death) Last Due to (or as a conseque nce of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 6 use contribute to the cause of death? the 3 □ Probably 4 ☑ Unknown 2□ No signed by þ pe 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy BBRTRS performed? has ETENSION 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No Medical Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Mobth, Day Year) 1 Natural 5 Pending investigation 1 | Yes 2 → No 1402ACENTESIS 2 Accident 2 efter death iractor: A Location (Street and Number or Rural Boyte Number, City or Town, State) 301 Sunt Paul Pl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 늄 HOSPITA-Me2cy Lates Property Substitution of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. NRZCY To the Hospital
within 24 hours of
To the Funeral Completely filled Hospital (Check only 2 ☐ Medical Examiner: On the basis of examiner stated. nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Mbnth, Day, Year) 29b. Signature and title of certifier 29c. License number 10 30142

eted cause of death (Item 23a) (Type, Print)

~ D

30155

21202

State Registrar 30. Name ar

31. Date filed (M

address of person whe

20000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Day 1:02 PM David Anson Swick 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Laurel Regional Hospital Prince George's Laure If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 🛛 M 2 🗆 F Nov 11, 1925 Days Hours Min. New York **Director** 133-16-4273 86 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20904 3116 Gracefield Rd #318 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 4 Yes 2 No 1943 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: white If Yes Give 1946 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8 physicist Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ Hannah Finke David Aaron Swick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 Gracefield Rd #318; Silver Spring, MD 20904 Elouise Swick - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature . Funeral Service License 22. Name and Address of Facility State Anatomy Board Mrector 655 W. Batlimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or nearly failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cardiac Phylician Arrest disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Pneumonia Exami law requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Yes 2 No signed by the a d be detached f g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinson's Disease, Congestive Heart Failure, Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Fall, Rib Fracture, Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has k autopsy performed? Yes 2 No Hospital or Attending Physician: The Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: _2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this s after death.

I Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: pull in injury C30 ☐ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Assisted Living Facility AM 2 Accident 3 Suicide Pecember 20 Investigation 28e. Place of Injury - home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 6 Could not be determined City or Town, State 3116 GMICO Facility hin 24 hours af the Funeral Di mpleted filled ir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the complex 29b. Signature and title of certifier

State Registrar park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laure | Regional Hospital

Registrar's Signat

Shanmugam

29c. License number 1)50412

7300 Van Dusen Road

29d. Date signed (Month, Day, Year)

02/08/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 540 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Min. (Month, Day, Year) Director 103-40-8766 1 XM 2 □ F 54 May 22, 1957 New York show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director ms 23a or 28a-f s must be notified 1 Yes 2 XNo MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 304 Bentley Ct. ural", or items 2 Examiner mus death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, unk Armed Forces?
1 Yes 2 No . or i Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examin 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.

'is marked other than "natur raumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gerald Lancelot Shank Rose Mae Wire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unkBetsy Johnston - cousin Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) Rona Ld 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed -tran and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as the k the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No detached for Day Pregnant at time of death 1 ☐ Yes ∠ ∟ 9 ☐ Unknown 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Junknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 21 No Other: 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 🖊 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28c. Injury at work? 28a. Date of injury 28b. Time of s after death. I Director: After t 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending М Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Padical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

Johns Hopkins Community Center Ste204 Hagerstown, MD 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sarita Sharma

FEB 1

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | 1 | State Amend Item | State of Mar 21 per fh,g | yland / Depa 24,027177 Ceri | rtment of F 2012dhb ificate of L | lealth a Death | nd Mental Hy | giene Reg. No. 🤈 🕻 | 212 01670 |
|-------|----------------------------|---|-----------------|--|---|---|--|----------------------|---|------------------------------|---|
| | | Physicia | | Decedent's Name (First, Middle, La | st) | tover | | | 2. Date of De | ath C | 3. Time of Death ZO12 5813P M |
| | | Medic Examin | | 4a. Facility Name (if not institution, given Doctors Community | | | 4b. City, Town, or Lan | | Death | | ty of Death |
| | | Funeral Director | | Usual Residence of Decedent | I □ M 2 X F | 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hours | Min. (Month, Da | y, Year) | 9. Birthplace (State or Foreign Country) South Carolina 10d. Inside City Limits |
| ~ | : | the Maryland or 28a-f sho oe notified at | I Director | The state of the s | Georges | Oc. City, Town or Loc | | | | 10g. Citizen of | 1X Yes 2 No What Country? |
| 7 | : | h with ns 23a nust k | Funeral | 3120 Parkway | | | 207 | | | | ed States |
| met | 215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | þ | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ▼ Widowed 4 ☐ Divorced | 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. | If | Yes, specify Cuba | n, Mexican, Specify: | n? (Specify Yes or No- Puerto Rican, etc.) | Specif | , |
| A | 21215- | vithin 72 ho iene. r than "na the Medic | Completed | 15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12th grade | | (Give ki | ent's Usual Occup ind of work done of NOT use retired) isory/Cu | during most o | | United | Business/Industry 1 States 1 Services |
| (| pu : | filed v al Hyg d othe | Be | 17. Father's Name (First, Middle, Last) | | | | | 's Name (First, Middle, | | ne) |
| E | Maryland | uld be I Ment narke natic e | 잍 | Rufus Addi: | | | | | rrie Dol | | |
| JC | Mai | 2 shoo | - | 19a. Informant's Name/Relationship (Lorraine Stover | | | | | or Rural Route Numberly, Mary | | |
| 54 | 3altimore, | age 1 and ent of Hea nt: If item y or other | | 20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Spec | Removal from State | 20b. Place of Dispos cemetery, crem | sition (Name of atory or other plac | e) I | Peb.7,2012 | 20c. Location | n - City or Town, State |
| | Baltii | permit. F Departm Importa any inju | | | Robert K | Smith 22. | Name and Addres | ss of Facility | R. N. Hort | on Comp | eany Morticians, hington,D.C.20011 |
| | | hy_ician/ Medical | | 23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | one cause on each line. | e death. Do not enter | r the mode of dyin | g, such as ca | ardiac or respiratory a | | Approximate Interval Between Onset and Death |
| | | cate be executed physician and s the burial-transit | al Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a c | | ıγ | | | | |
| | 760 | cate b physical physical physi | ledical | | d | | | | | | |
| ME/FE | Box 687 | Hospital or Attending Physician: The law requires that the death certificate be executed by 4 hours after death. Funeral Director, After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transi | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown | Fetal death 3 | Ectopic pregnand Other (specify) | су | | I | Date of delivery Month Day Year |
| | ds, P.O | requires that the des been signed by the s should be detached | ted by Ph | Part II. Other significant conditions | contributing to death but | not resulting in the ur | nderlying cause giv | ven in Part I. | | Yes 2 ☐ No | ntribute to the cause of death? 3 □ Probably 4 ☑ Unknown |
| | Recor | : The law re cate has be ; page 2 sh | Completed by | | | | | | 1 🗆 Yes | | b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| | ital | sician certifi irector |) Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | : 2 ☐ ER/Outpatien | Lau | 0.81 | (Check only one) sing Home 5 Res | idanaa 6 🗆 Oi | Shor (Specify) |
| | Division of Vital Records, | To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 | Certificate: To | 27. Manner of Death 1 | 28a. Date of injury (Month, Day, Y | | 28c. Injur work | y at | 28d. Describe | how injury occu | |
| | ivisio | l or Afte after de Directo d in by th | Certif | 3 Suicide 6 Could not 4 Homicide determined | | - At home, farm, stre Specify) | et, factory, office | | 28f. Location City or To | Street and Num wn, State) | ber or Rural Route Number, |
| | <u>:</u> ت | ne Hospita n 24 hours ne Funeral pletely filled | Medical (| 29a. Certifier 1 Certifying Ph (Check 2 Medical Exar only one) 3 Certifying Nu | ysician: To the best of my niner: On the basis of exar rse Practitioner: To the b | mination and/or investi | igation, in my opinio | on, death occ | curred at the time, date | and place, and c | due to the cause(s) and manner stated. |
| | | To the To the Comple | | 29b. Signature and title of certifier from M | | | 29c. License | | | 29d. Date sign | ned (Month, Day, Year) |
| | • | (2) | | 30. Name and address of person who | | , | | ham. r | naryland | 20706 | |
| | | Sta Registra | | 31. Date filed (Month, Day, Year) | 32, Registrar's | | | , , | | | |

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ Day 9 February Tyrone Laverne Sigler 11:58 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 925 Shirley Manor Road Reisterstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours (Month, Day, Year) **Director** 219-38-0884 1 M 2 🗆 F 72 Yrs. Usual Residence of Decede July 28, 1939 Maryland 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Reisterstown 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a on event, the Medical Examiner must be Funeral 925 Shirley Manor Road 21136 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. 3 Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other ti Steamship Co Office Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Leonard Sigler, Sr. Camille Alice Shaffer permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Pellicano Cousin 548 Ocean Parkway Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2X Cremation 3 \square Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 2/11/12 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road hen ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph si i n elanon 4241 disease or condition Medical resulting in death) Due to (or as a consequence of) Syndremy Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) INSON burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical 2 Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death signed by the at d be detached f Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Cunknown plnous Were autopsy findings available prior to completion of cause of death? iciency anemia 24a. Was an page 2 autopsy perforn AVONTO lain certificate 1 Yes 2 KN 2 100 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) (2 1 XYes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/2 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4004579 Feb. 10 ancisi En 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) tre ste 100 Baltingle un

Registrar DHMH 17 Rev 06-2011

State

Francis(Date filed (Month, Day, Year)

FEB

1 3 2012

3350

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year MARTHA SAWYER 5:39 PM JANE FEBRUARY 15 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BALTIMORE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 217-40-1366 1 🗆 M 2 🔀 F 69 Yrs April 03 1942 MD 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 🗆 Yes 2 😾 No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21226 212 Sycamore Road USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: White 3 Widowed 4 ☐ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William McClean R. Mulquin Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Sawyer (son) 3315 Kessler Court, Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Cemetery Glen Burnie, Maryland 2012 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ah. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final SOFT TISSUE INFECTION 10 SHOCK SEPTIC DUE resulting in death) Due to (or as a consequence of): 2° SEPTIC SHOCK KIDNEY INJURY ACUTE Due to (or as a consequence of Due to (or as a consequence of)

Ph. i.i.n. Medical Examiner

> -tran and

Physician: The law requires that the death certificate be executed

signed by

ours after death. eral Director: After this certifica filled in by the funeral director,

24 hours a

Hospital or Attending

Division of Vital Records, P.O. Box 68760

Examine

Physician/Medical

Completed by

Be

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Certificate:

Medical

Department of Important: If any injury or once.

Physician/

Medical

10a. State

Examiner

Funeral

Director

or 28a-f show notified at

ō

items 23a or ner must be n

"natural", or iten edical Examiner r

Medical

than

realth and Mental Hygiene.
To 27 is marked other than through the traumatic event

. Page 1 and 2 sh tment of Health a t: If item 27 i or other tra Director

Funeral

by

Completed

Be

2

within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown

23d. Date of delivery Dav

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION

HYPERLIPLDEMIA

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy Yes

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

2 No

2012

Year

25. Was case referred to medical examiner? 1 🗆 Yes 2 🖼 Ko 27. Manner of Death 1 Natural

29b. Signature and title of certifier

Accident

2 Acciden

4 Homicide

Hospital 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 5 Pending

28c. Injury at work?
1 Yes 2 No

Other:

1 Yes 4 Nursing Home 5 Residence 6 Other (Specify)

29a. Certifier

Investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number RES-001

HOSPITAL

29d. Date signed (Month. Dav. Year)

15

FEBRUARY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

o Fasy

MD

ANDREW

32. Registrar's Signature

HARBOR

31. Date filed (Month, Day, Year) FEB 1

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G924, 2/27/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar amend #7 Per FH G924 2/28/2012 Beath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 5:08 M TAN 2012 Medical Herbert <u>Schulmar</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Univ. of Maryland Medical Ctr Baltimore Month Day, Year) 27 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Days Hours Min. New York 83 -84 **Director** 055-20-0083 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1X Yes 2 ☐ No DC Washington, DC 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 5420 Connecticut Ave. NW #717 20015 USA 12. Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? 1 X Yes 2 □ No 1955-If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White 1957 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. other than " College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Private Industry should be filed with and Mental Hygien 7 is marked other tl Psychiatrist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Benjamin Schulman Martha Adler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Schulman/Wife 5420 Connecticut Ave, NW, Wash, DC 20015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Howard Univers Medical School 1 Burlal 2 Cremation 3 Removal from State 1ty 1/10/2012 4 X Donation 5 ☐ Other (Specify) Washington, 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Fundal Service Licer 10 3821 14th Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ a Subdural Hemorrhage disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Fall ATION APPROVED ON MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFI Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown signed by the a ld be detached f 1 Yes 2 L P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has birector, page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No Hospital: 1X Yes ပ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 1 / 5 / 1 2 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 🔀 No Certificate: 28d. Describe how injury occurred ☐ Natural injury 5 Pending Accident Investigation unknowh Fall filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 4 2 0 Conn • Ave • NW D • C • 4 ☐ Homicide determined Home Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of symmetries and/a limitation of the cause (s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сотріете (Check within 2 To the only one 29c. License number 29d. Date signed (Month, Day, Year) D66267 Feb. 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali Tabatabai Greene St., Baltimore, Md 21201 31. Date filed (Month, Day, Year) State 2012 acks Registrar

DHMH 17 Rev 7/2009

12-01277

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| /Jark Ryan Sum | mei | 1- For State | State of Maryla | | artment of rtificate of | | d Mental I | | | 012 0467 | |
|--|--|--|---|-------------------|--|--|-----------------|----------------------|----------------------|-----------------------------------|--|
| Physici | an/ | Registrar 1. Decedent's Name (First, Mic | ddle,Last) | | | | | 2. Date of Deat | g. No. h | 3. Time of Death | |
| Medical Exami | | Mark Ryan Sur | nmers | | | | | Month February 1 | Day Year 12, 2012 | | |
| | | 4a. Facility Name (if not institute | | nber) | 4 | o. City, Town, or | Location of Dea | | 4c. County of | Death | |
| | | 916 Haven Place | 619 Haven 1 | Place | | Edgewood | | | Harford | | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. I | ast birthday) | If Under 1 Yea | | | h (MM/DD/YYYY) | 9. Birthplace (State or | |
| Director | | 145-96-7777 | 1× M 2 F | 17 | Yrs. | Months Days | s Hours M | in. May 31 | . 1994 | Foreign New Jersey Country) | |
| | | Usual Residence of Decedent | | | | | | Tracy JI | 1994_1 | | |
| w any | or | 10a. State 10b. Count | • | | Town or Location | n | | | | 10d. Inside City Limits | |
| ryland a-f show | | Maryland Harfo | ord | Edg | gewood | | | | | 1 Yes 2 X No | |
| Mary 28a- | Director | 10e. Street and Number | | | | 10f. Zip Code | | 10 | g. Citizen of Wha | it Country? | |
| th the Maryland 23a or 28a-f sho notified at once, | | | | | | | USA | | | | |
| h wit | Funeral | 11. Marital Status 1 Never Married 2 | | edent Ever in U. | | Decedent of His s, specify Cuban | | Specify Yes or No- | 14. Race - White, | American Indian, Black, | |
| or its | Fun | | 1 Yes | 2 🔀 No | | | | 10 1110011, 010.) | | | |
| s afte | ğ | | Divorced If Yes, Give Yaar or Dates: | | | | specify: | | | White | |
| hour natu | ted | Decedent's Education (Sp Elementary/Secondary (0-12 | | | | s Usual Occupat st of working life. | | | 16b. Kind of Busi | ness/Industry | |
| 36 iin 72 than dical | ple | 12 | :) College (1- | 4 or 5+) | Q1 1 | | | | High So | rhool | |
| 5-0036 led within 7 Hygiene. other than | To Be Completed | ⊥∠ 17. Father's Name (First, Middl | e. Last) | | Studen | | 18.Mother's Nan | ne (First, Middle, M | | 11001 | |
| 21215-(uld be filed v Mental Hygi marked oth | | Mark Charlton | | | | | | (nmn) Cla | · | | |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sh matte event, the Medical Examiner must be notified at once | | 19a. Informant's Name/Relation | nship (Type, Print) | | 19b. Mailing | Address (Stree | | Rural Route Num | | State, Zip Code) | |
| MD 2121 12 should be fi th and Mental I 127 is marked umatic event, | | Susan Summers | s / Mother | | 619 на | aven Pla | ace, Edo | jewood, M | arvland | 21040 | |
| _ 2 d # f | | 20a. Method of Disposition | | | Place of Dispositi crematory or other | on (Name of cer | netery, | Date | 20c. Location - 0 | City or Town, State | |
| Baltimore, permit. Pages I an Department of He Important: If ite | | 1 Burial 2 Crematic | | in Otate | lington | | v 2_ | 19-2012 | Toppa | Maryland | |
| Baltir permit. P Departme Importar injury or | | 21. Signature of pheral Service | | | | | | Comas Fu | neral Ho | maryranu me D A | |
| E P P P | | 14/2/ | 1119-1 | | 133 | 7 Cokes | burv Ro | ad. Abin | odon. Ma | ryland 21009 | |
| Physician | | 23a. Part I. Enter the disease, of | | used the death. | | | | | | t Approximate Interval | |
| /Medical | | failure. List only one cause Immediate Cause (Final disease | | itie | | | | | | Between Onset and Death | |
| Examiner | Immediate Cause (Final disease or condition resulting in death) a. Myocarditis Due to (or as a consequence of): | | | | | | | | | | |
| | _ | Sequentially list conditions, | b | Orrest Control | _ | | | | | | |
| | Examiner | if any, leading to immediate cause. Enter Underlying Caus | | consequence of | f): | | | | | | |
| | хац | (Disease or injury that initiated events resulting in death) Last | | consequence of | f): | | | | | | |
| oo. | | | | | | | | | | | |
| be executed iician and iirial - transi | dical | x AMENDED 4a, per me, g924 2-17-12 sm 23a, 27, per me, g925 3-23-12 sm | | | | | | | | | |
| x 68760 th certificate b tending physicase as the bu | 31 | IF FEMALE: | 23c. If yes, ou | utcome of preg | | W120 - 114 - 125 | _ | | 23d. Date of d | • | |
| Box 6876(death certificate the attending physelfor use as the b | Ë | past 12 months? | | | | | | Day Year | | | |
| 30X death e atte | Ş | 1 Yes 2 No 9 U | nknown 9 Unknov | | 5 Othe | er (Specify) | | | i | ì | |
| . 4 54 | | Part II. Other significant cond | itions contributing to | death but not re | esulting in the un | derlying cause g | iven in Part I. | 23e. Did tol | pacco use contribi | ute to the cause of death? | |
| , P. | d b | | | | | | | 1 Yes | 2 🗸 No 3 | Probably 4 Unknown | |
| rds requir | Completed | | | | | | | 24a. Was a | | | |
| e law e has | 副 | | | | | | | autops perform | ned? de | or to completion of cause of ath? | |
| tal Reco | | 25. Was case referred to medic | and I | | | 26 Plans | of Death (Check | 1 Yes 2 | No 1 | Yes 2 No | |
| is cert | 8 | examiner? | Hospital: | nationt 2 | ER/Outpatient | | Other Nurs | | Residence 6 | Other Scene | |
| on of Vital Records, P.O. Box ending Physician: The law requires that the death ath. or: After this certificate has been signed by the atte the funeral director, page 2 should be detached for u | £. | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date o | f Injury | 28b. Time of Inju | | y at Work? | | ow injury occurred | | |
| SION OF Attending Ph r death. ector: After t | 틸 | | (Month, t | Day,Year) | | 1 □ Y | es 2 No | | | | |
| THE PROPERTY OF ACCIDENT Investigation | | | | | treet and Number or Rural Route Number, City | | | | | | |
| DIVI ppital or ours afte teral Dir filled in | 핗 | Suicide 6 Could not be determined (Specify) Suicide 6 Could not be determined (Specify) | | | | | | | | | |
| Hosp 24 hor Func tely fi | Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Rour or Town, State) 28g. Certifier (Specify) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | s stated. | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and and manner stated. 29b. Signature and title of certifier 29c. License number O. C.M.E. | | | | | | | | | | | |
| U B B B | ž | 29b. Signature and title of certif | | | | 29c. License | number | | 29d. Date signed | (Month, Day, Year) | |
| | | Kuniota Deur | hell mo | | | O.C.N | Λ.E. | İ | February 13 | , 2012 | |
| Obord | ı | 30. Name and address of perso | | • | • | | | | | | |
| | | Pamela E. Southall, | | ledical Exa | miner 900 | W. Baltimore | Street, Balt | timore, MD 21 | 223 | | |
| St Regist | ate | 31. Date filed (Month Day Year | 32. Reg | irar's Signatu | ir de l | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #30 Per Dyr C924, 2/17/2012 JH

amend #30 Per Dyr C924, 2/17/2012 JH

beginning to Health and Mental Hygiene

| | | • | 1 - State Of IVIA | Cer | tificate of L | | Reg | . No. 2012 | 04675 | | |
|--|--|----------------------------|--|--|---|---|-------------------------------------|-------------------------------------|---|---|--|
| | Physicia | ın/ | Decedent's Name (First, Middle, Last) | | | | 2. Date of Death | Day Year 13,2012 | 3. Time of Death | | |
| Medical Examiner | | | MARJORIE VIOLA SMITH 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | | FEBRUARY | 13,2012 4c. County of Deat | 8:30A M | | | |
| Examiner | | | 3326 WOODSIDE AVENUE | PARKVILLE | | | BALT | | | | |
| | Funeral | | | (In yrs. last birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Ye | 9. Birt | hplace (State or Foreign | | |
| | Director | | 217-12-6875 Usual Residence of Decedent | 90 Yrs. | | | 11-12-19 | 21 PEN | NSYLVANIA | | |
| 2 | rland f shov | tor | 10a. State 10b. County | 10c. City, Town or Loc | | | | | 10d. Inside City Limits | | |
| | e Man 28a- notifie | Director | MD BALTO. | | PARKVILLE | | | | 1 Yes 2 No | | |
| | vith th | | 3326 WOODSIDE AVENUE | | 10f. Zip Code 21234 | ' | 109 | g. Citizen of What Co USA | untry? | | |
| | leath v | Funeral | 11. Marital Status 12. Was Decedent Ev Armed Forces? | ver in U.S. 13. V | | ispanic Origin? (Spe In, Mexican, Puerto I | cify Yes or No- | 14. Race - Amer | | | |
| 36 | e filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | d by | 1 Never Married 2 Married 1 Yes 2 Xh 3 Xwidowed 4 Divorced Year or Dates. | lo l | Yes 2 X No | | nicari, etc.) | Specify: W | e, etc. HITE | | |
| 21215-0036 | natur dical l | plete | 15. Decedent's Education (Specify only highest grade completed) | 16a. Deced | dent's Usual Occupa | ation during most of working | 16 | Sb. Kind of Business/ | Industry | | |
| 121 | within 72 giene. er than * | To Be Completed | Elementary/Secondary (0-12) College (1-4 or 5- | -) life. Do | O NOT use retired) | duning most of worki | ng | HOME | | | |
| d 2 | filed wil al Hygie d other vent, th | | 12TH 17. Father's Name (First, Middle, Last) | HO. | MEMAKER | 18. Mother's Name | e (First, Middle, Mai | HOME | | | |
| /lan | uld be fil Mental narked natic ev | | ERNEST DERLING | | | | (, | | | | |
| re, h | 2 shoulth and 27 is not rtraum | | 19a. Informant's Name/Relationship (Type, Print) ROBERT M. SMITH SOI | | | | | ty or Town, State, Zip TLLE,MD 2 | | | |
| | or it | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | sition (Name of natory or other plac OF FAITH | e) | -2012 BA | C. Location - City or | Town, State | | |
| Balti | permit. Page Department of Important: If any injury or once. | Ì | 21. Signature of Funeral Service Licensee | 22 | | ss of Facility SCI | | UNERAL HO | | | |
| | | Н | 23a. Part 1. Enter the disease, or complications that caused | the death. Do not ente | | | | | Approximate | | |
| | tsystetan/ | | shock, or heart failure. List only one cause on each line. Interval Between Oneet and Death disease or condition | | | | | | | | |
| | Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | | | | | | |
| | | Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (u)sease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | |
| 299 | ificate be executed g physician and as the burial-transit | | | | | | | | | | |
| 0 | e be ey ysiciar ne buria | | d | | | | | | | · | |
| 876 | tificate ng phy e as th | | IF FEMALE: | | | | | | | | |
| Due to (continue to the continue to the contin | | | | uncome of pregnancy ve Birth 2 □ Fetal death 3 □ Ectopic pregnancy egnant at time of death 5 □ Other (specify) | | | | 23d. Date of del Month | ivery Day Year | | |
| Ö. | the de | hysi | 1 Yes 2 No 9 Unknown 9 Unknown | inne or death or | Other (specify) | | | | | | |
| Р. | requires that the des been signed by the s should be detached | ρ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| rds | require | eted | | | | | | | | | |
| Division of Vital Records, | sician: The law rs certificate has the | Completed | | | | | 24a. Was an autopsy performe | prior to death? | topsy findings available completion of cause of | | |
| al B | ian: Ti rtificat ctor, p | Be C | 25. Was case referred t edical examiner? | 1 Yes 2 No 1 Yes 2 No | | | | | 2 _ No | | |
| Z. | hysic this ce al dire | 은 | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie | t 2 DER/Outpatient 3 DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) | | | | | | | |
| 0 U | Attending For death. ector; After by the funer | Certificate: | 27. Mann of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, | | | | | | | | |
| risio | r Atter er dea rector by the | ertifi | 3 Suicide 6 Could not be | y - At home, farm, stre | | | | et and Number or Rui | ral Route Number, | | |
| Di | pital or ours afte eral Dir filled in | | | | | 1 | City or Town, S | | -1 | | |
| | To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director, After this certifica completely filled in by the funeral director, | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of many one) 3 Certifying Nurse Practifioner: To the | amination and/or invest | igation, in my opinio | on, death occurred at | the time, date and p | place, and due to the o | cause(s) and manner stated. | | |
| | To the within 2 To the comple | - | 29b. Signature and title of optifier | | 29c. License | | 290 | . Date signed (Month | | | |
| | 10 | | 30. Name and address of person who completed cause of de | ath (Item 23a) (Type, P | Print) | 10 113 | 0 | 1 | / 🤄 | | |
| | 6 | | Mahamad Reza Rahnama 9 | 512 HArfor | | lto,MD 21: | 234 | | | | |
| | Stat Registra | e ar | 31. Date filed (Month, Day, Year) FEB 1 7 2012 62. Registrar | 's Signature | Les . | | | | | | |

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 14,2012 Charles Michael Spangler February 4:30A. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 9019 Cowenton Avenue Perry Hall Balto. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 10-20-1953 Min Maryland Director 220-62-1645 1 X M 2 D F 58 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** notified Md. Balto. Perry Hall 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ò must be 9019 Cowenton Avenue 21128 USA items ner mu permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X/es 2 No Black, White, etc. Examin ō þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White If Yes, Give Year or Dates. 1973–1979 "natural" 3 Widowed 4 Divorced Completed er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Self-Employed Service ed other event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental F 27 is marked of ir traumatic ever ၉ William A. Spangler, Sr. Theresa M. Kalista 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry Hall, Md. 21128 Sharon Spangler Spouse 9019 Cowenton Avenue of Health item 2 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of I Important: If it any injury or or once. cemetery, crematory or other place) 1 🔲 Burial 2 🛣 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-17,2012 Glen Burnie, Md. Atlantic Crematory Schimunek Funeral Home, Inc. ere of Funeral Service 22. Name and Address of Facility . Signat 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Imall Cell Lung disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and use as the burial-trar Due to (or as a consequence of) attending physician a for use as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No has page 2 this certificate Division of Vital Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \nearrow Residence 6 \square Other (Specify) 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director; After injury 5 Pending 1 Matural Accident Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) 0 D26817 2012 11 npleted cause of death (Item 23a) (Type, Print) + Baltimore MD 21201

Registrar DHMH 17 Rev 06-2011

State

address of person who complete

Robert

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2012 7:16A M February John Wesley Sturdivant Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 X M 2 □ F **Director** 054-18-9630 01/01/1922 Virginia 90 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Director notified 1 Yes 2X No Maryland | Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö Funeral 23a United States 21061 530 Joy Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. Jo. 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. **Black** 21215-0036 1 ☐ Yes 2 🗓 No Specify. If Yes, Give "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates d Mental Hygiene. marked other than "natur matic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Post Office 8 Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) ပ္ Mintie Tanner Robert Sturdivant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 530 Joy Circle, Glen Burnie, Maryland 21061 27 JoAnna Washington/ Daughter Department of Healt Important; If item 2 any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Calverton Ntl Cemetery 02/17/2012 Long Island, NY 4 Denation 5 Other Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home
421 Crain Highway S.E., Glen Burnie. MD 21061 Part 1. Enter the dis, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the dis Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ HC Medical **Examiner** Sequentially list conditions, if any sead of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequence of: or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Recepant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant Day Month in the past 12 months? Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerefrormalax accident 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X**No Yes 2 No 1 Yes the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d Describe how injury occurred 27. Manner of De Certificate: within 24 hours after death. To the Funeral Director; After Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configure Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29h. 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) . Registrar's Signature

State Registrar

ORIGINAL

Please Type c. Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 4:30 AM FEBRUARY 16 Smyth 2012 Joseph James /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CAM If Under 1 Year | If Under 24 Hrs. Social Security Number Sex 11∰M 2□F Age (In yrs. last birthday) 8. Date of Birth 04/16/1926 **Funeral** Days Months Hours Min Yrs. 85 Pennsylvvania 202-18-2175 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2XXVo Directo Harford Aberdeen Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 841 Lynn Lee Drive 21001 USA Funeral within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tyes 2 No 1944— If Yes, Give Year or Dates: 1949 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: ş White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wir Department of Health and Mental Hygien Important: If Item 27 Is marked other the any Injury or other traumatic event Civil Service US Government 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ F. Smyth Ebba Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 841 Lynn Lee Drive, Aberdeen, Maryland 21001 Sheila Grace (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery Fremont 2/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Nottingham, PA 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that couled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2005 /Medical Due to (or as a consequence of): Examiner nlu 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examiner law requires that the death certificate be executed transi and physician at the burial-t Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💋 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe certificate I 2 ☑ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Dire filled 29a. Certifier 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number D2927 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

OSEPH J. SMYTH

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

State Registrar

-DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

PATRICIA

parks

32. Registrar's Signature

(1840)14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

65

| 2-01065 lary C. Smith | State of Maryland / Department of Health and Ment | | 2 0468 | | | | | |
|--|---|--|---|--|--|--|--|--|
| | 1- For State Certificate of Death | Reg. No. | | | | | | |
| Physician/ Medical Examine | | Date of Death Month Day Year February 5, 2012 | 3. Time of Death 0043 hrs | | | | | |
| | 4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center 4b. City, Town, or Location of BelAir | Harford | | | | | | |
| Funeral Director | 5. Social Security Number 212-76-1337 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Bir Foreign Co. | | | | | | | |
| nd show any ace. | Usual Residence of Decedent 10a. State | | 10d. Inside City Limits 1 Yes 2 No | | | | | |
| the Maryland a or 28a-f show tified at once. Director | 10e. Street and Number 3919 Paddrick Road 21034 | 10g. Citizen of What Cou USA | USA | | | | | |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once TO Be Completed by Funeral Director | | | White | | | | | |
| 11215-0036 Id be filed within 72 hours after dental Hygiene. aarked other than "natural", event, the Medical Examiner. on Be Completed by F | 16 December 5 Augustion (Specific only highest grade completed) 16a December's Itsual Occupation (Give highest grade completed) | | | | | | | |
| 21215-0036 wild be filed within 7 Mental Hygiene. marked other than ic event, the Medical To Be Compile | | 's Name (First, Middle, Maiden Surname) Mary C. Schreiner | _ | | | | | |
| MD 2121(d 2 should be fill th and Mental H n 27 is marked numatic event, I | 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num | nber or Rural Route Number, City or Town, State Dad, Darlington MD 210 | e, Zip Code) 034 | | | | | |
| Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Crematory | Date 20c. Location - City o 2/10/12 Hanover Ma | | | | | | |
| Baltir permit. 1 Departm Imports injury o | 21. Signature of Funeral Service Licensee Victor P. Doda 22 Name and Address of Facility Charles L. Steven 1501 E. Fort Av. | vens Funeral Home, Inquenue, Baltimore MD 2 | T230 | | | | | |
| Physician Wedical | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A principle of dying, such as cardiac or respiratory arrest, shock, or heart Between One Death | | | | | | | |
| Examiner | Immediate Cause (Final disease or condition resulting in death) a. Amiltriptyline, Fluoxet.ine, and alcohol intoxication Due to (or as a consequence of): | | | | | | | |
| in the state of th | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| executed an and al - transit | events resulting in death) Last Due to (or as a consequence of): d. | | | | | | | |
| ੂ ਜ਼ਾਜ਼ ਹ | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burity conficient Contributed by Director and Madrical Madrical Contributed by Director and Madrical Madr | FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 V Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic 5 Other (Specify) 9 Unknown | c pregnancy 23d. Date of delive | Day Year | | | | | |
| res that the de signed by the be detached for the by the detached for the by the by the by by | | | o the cause of death? | | | | | |
| Records, For The law requires ficate has been sign, page 2 should be | | autopsy prior to performed? death? | | | | | | |
| tal Rections: The certificate ector, page | | (Check only one) | res 2 No | | | | | |
| Vital Rec ysician: The l his certificate l director, page | examiner? Hospital: Innationt 2 ER/Outnationt 3 DOA Other | Nursing Home 5 Residence 6 Oth | er: | | | | | |
| nding Ph. th. :: After the funeral | 27 Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work? 28d, Describe how injury occurred | | | | | | | |
| Division o spital or Attending sours after death. neral Director: After filled in by the func | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Found: Residence | tc. 28f. Location (Street and Number or F or Town, State) 39199 Pa Darlington, Md. | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 39199 Paddrick Rd. | | | | | |
| Division of To the Hospital or Attending Phywithin 24 hours after death To the Funeral Director: After the completely filled in by the funeral | | | | | | | | |
| To with Tour | 29b. Signature and title of certifier O.C.M.E. | 29d Date signed (M February 5, 201 | | | | | | |
| 9- | 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, | MD 21223 | | | | | | |
| Staf | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\mathbf{Feb}^{\mathsf{Month}}$ Physician/ William Warner Staley 20^{Year}2 10:43 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Genesis HealthCare The Pines <u>Easton</u> Birthplace (State or Foreign Country)
 NJ Age (In yrs. last birthday) 90 yrs. 8, Date of Birth **Funeral** Min. 1 🕱 M 2 🗆 F Days Hours 176-18-0477 0272271921 **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland at Director Easton injury or other traumatic event, the Medical Examiner must be notified Talbot 1 🗆 Yes 2 і No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26256 Milesview Road #1A 21601 items 23a Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other transcript. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛮 No Specify: Specify: White If Yes, Give 1 942-45 Year or Dates. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Staley Elementary/Seconday (0-12) College (1-4 or 5+) Space Technology Mechanical Engineer 4yrs Be t, Middle, Maider Warner 17. Father's Name (First, Middle, Last) Mother's Name (Eirst Mildred Joseph F. Staley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26256 Milesview Rd #1A Easton MD 21601 19a. Informant's Name/Relationship (Type, Print) Wife Helen R. Staley 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Atlantic Crem 1 Burial 2X Cremation 3 Removal from State 2/13/2012 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licenses ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer shock, or heart failure. List only one cause on each ling set d eath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2
Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day cate has been signed by the atter page 2 should be detached for Month Year Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? ant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autop-performed death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No iniury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

Name and address of person who completed cause

ROWLEY

William

DUTCHMAN'S

death (Item 23a) (Type, Print)

610

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ 1:00 P M 1/2 Medical 4a. Facilify Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ridgeway Manor Nursing Home Baltimore Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 215-18-5491 Director 1 □ M 2 🔀 F 91 2/18/1920 PA Usual Residence of Deceder 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at the Maryland Director 1 Yes 2 X No Halethorpe Baltimore MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with USA 21227 4230 Hollins Ferry Road, Apt 105 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No ģ 1 Never Married 2 Married Maryland 21215-0036 ner than "natural", or t, the Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify. Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mfg. Ouality Control Inspector Я Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Elsie Koontz Alfred Kight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; if item 27 is any injury or other traunonce. 7959 Pipers Path, Glen Burnie, Maryland 21061 Robert Lewis / Nephew altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 2/17/2012 Baltimore, Maryland Donation 5 Other (Specify) Loudon Park Cemetery 22. Name and Address of Facility Hubbard Funeral Home, Inc. ture of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. ician/ puturelle disease or condition Medical resulting in death) r as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-transi Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the at Id be detached fo Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Waknown Division of Vital Records, 1 Yes To Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an deverter autopsy this certificate has ral director, page 2 1 Yes 2 No 1 Yes 2 LNO 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: funeral director, Other: 1 Tyes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After injury 1 Natural 5 Pending Accident Investigation filled in by the within 24 hours after deal To the Funeral Director Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my office of the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 966 7012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 61:020ine, 8/d 21061 itchie Hichory 508

Registrar DHMH 17 Rev 06-2011

State

wasiis

310 Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Wilson Year Physician/ 8:05° M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth curity Number **Funeral** Min (Month, Day, Year, 215-16-5064 **Director** 1 X M 2 □ F 8 MD Usual Residence of Decedent 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director 1 Yes 2 No TMOVE o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) NIA Le ceptionis Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) ည Wilson LVISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1 Approximate shock, or heart failure. List only one cause on each line interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Non-small-cell-lung menth Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any Leading to immediate cause. Enter Underlying Examine Due to lor as a consequence of The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No Director: After this certificate To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred Certificate: 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Aditya Jain MD MPH 14th, 2012 AT2438946-D7 February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 201 E. Whiverity Pkwy State

DHMH 17 Rev 06-201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ FEBRUARY **EVELYN** 13 2012 2:40 P M WOOD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4116 BEACH CRAFT COURT TEMPLE HILLS PRINCE GEORGE'S 8. Date of Birth (Month, Day, NOV • 6 **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Days Hours 1935 WASHINGTON, DC Director 577-50-1474 76 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 X Yes 2 No MD PRINCE GEORGE'S TEMPLE HILLS 10e. Street and Number ō 10g, Citizen of What Country? 23a Funeral 4116 BEACH CRAFT COURT 20748 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. ō þ 1 X Never Married 2 Married ☐ Yes Yes, Give 2 XNo Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: BLACK Specify "natural", 3 Divorced 4 Divorced Completed Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical" 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9th COOK PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ ANTHONY C. WOOD HOWARD LUCY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a CASSANDRA REED/DGT. 1502 LORELEI DRIVE FT. WASHINGTON, MARYLAND 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 M Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) 2/20/2012 SUITLAND, MARYLAND LINCOLN CEMETERY 22, Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) ENDOMETRIAL CANCER Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cauca. Error Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ó 4 Pregnant a Month Day Pregnant at time of death 5 Other (specify) detached Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the Division of Vital Records, P.O. s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X 25. Was case referred to medical examiner?
1 Yes 2 XNo funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 x Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending Accident Suicide Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one)

State Registrar 29b. Signature and title of certifie

DHMH 17 Rev 7/2009

completed dause of death (Item 23a) (Type, Print)

MD

1221

PFAFFENROTH

29c. License number

D68956

MERCANTILE LANE LARGO, MARYLAND 20774

29d. Date signed (Month, Day, Year) FEBRUARY 15, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILLIAMS 2012 MICHAI BARRACK **FEBRUARY** $11:38_A^M$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 2012 26 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2 □ F Months Mir Hours JANUARY MARYLAND Yrs **Director** NONE Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🕎 Yes 2 🗌 No MD PRINCE GEORGE'S SUITLAND ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be i Funeral 3700 ST. BARNABAS ROAD 20746 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: BLACK "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 NONE NONE other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည MICHAEL **JAFAR** WILLIAMS CELESTE other traumatic BROADWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is MICHAEL JAFAR WILLIAMS/FATHER 3700 ST. BARNABAS ROAD SUITLAND, MARYLAND 20746 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State injury or RIVERDALE CREMATORY 2/15/2012 4 Donation 5 Other (Specify) RIVERDALE, MARYLAND lure of Funeral Service Junsee 22. Name and Address of Facility J_{\bullet} B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EXTREME IMMATURITY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** SHOCK Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed burial-transi RESPIRATORY FAILURE that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical METABOLIC ACIDOSIS the attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? death? 2 No Yes 2**V** No Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 \(\Bigcap \) Nursing Home 5 \(\Bigcap \) Residence 6 \(\Bigcap \) Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1🏝 Natural 5 Pending injury work 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Walker

Registrar DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Vital

of

Division

MATTHEW PICARD M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sanature

D50522

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Earl Wenzel George 2012 9:25 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heart Heritage Estate Harford Street If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Hours May 16, Year) Marvland Director 213-20-2101 87 Usual Residence of Decedent artment of Health and Mental Hygiene. ortan: "I fitem 27a or 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎽 No Harford Maryland| Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 908 Charisma Ct. 21050 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black. White, etc. 1 Never Married 2 Married þ X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Manufacturer Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nellie Virginia Musgrove Joshua Hampden Wenzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Jane Shearman / Daughter 908 Charisma Ct., Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Remova from State Rose Hill Services, LtC 2-15-2012 Bel Air, Maryland ponation 5 Q Other (Specify) 21. Signature of Funer 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final END Denentin Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exam Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No by the a 1 L Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed s been sig should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗌 No 2 1 No 1 Tes Yes Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica eted filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Hospital: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Livina 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) in 24 hour.
io the Funeral Dicompleted filler Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615

W. 32. Pagistrar's Signature

SPARKUS

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Bel AIN MA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For | Sta | te of Maryl | - | ertment of Hea | | Mental Hy | giene | 0 01 007 | | | |
|--|--|-------------------------|--|------------------------------|---|------------------------------|--|----------------------|----------------------------------|--|--|--|--|--|
| | | | State Registrar | | | Cer | tificate of De | ath | | Reg. No. 2012 0468 | | | | |
| | Physician/ Medical 1. Decedent's Name (First, Middle, Last) LOW Rock (+. Wasse) | | | | | | | | 2. Date of Dea Month | The Pay 25 (2 | 3. Time of Death | | | |
| | Examir | | 4a. Facility Name (if not inst | titution, give street an | d number 23 | 4 | 4b. City, Town, or Loc | cation of Death | 1 7000 | 4c. County of De | ath | | | |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yi | s. last birthday) | | Under 24 Hrs. | 8. Date of Birt | | Birthplace (State or Foreign | | | |
| A _c t | Director | | 161-20-4126 | 6. Sex 1 🖾 M 2 | F | 84 Yrs. | Months Days F | łours Min. | July 8, | 1927 Per | insylvania | | | |
| | ind show at | | Usual Residence of Deceder 10a. State 10b. C | | 10c. | City, Town or Loc | ation | | | | 10d. Inside City Limits | | | |
| | Maryle 28a-f otified | irect | MD Mor | ntgomery | Si | lver Spr | ing | | | | 1 ☐ Yes 2 🛣 No | | | |
| | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral Director | 10e. Street and Number 1131 Univers | sity Blvd. | W #901 | | 10f. Zip Code 20902 | | | 10g. Citlzen of What (| Country? | | | |
| 99 | fter death ", or item aminer n | by | 11. Marital Status 1 ☐ Never Married 2 ₽ | Married Arm | Decedent Ever in ed Forces? Yes 2 \(\sum \) No es, Give 1045 | If | /as Decedent of Hispa Yes, specify Cuban, № Yes 2 No S | Mexican, Puerto | ecify Yes or No- Rican, etc.) | Black, Wh | | | | |
| ő | ours a atural' cal Ex | Completed | 3 Widowed 4 Div | vorced Year | r or Dates.1945 | -49 | ent's Usual Occupation | | | Specify: Wh | | | | |
| 215 | n 72 h e. ian "na Medi | du | (Specify only | y highest grade comp | ege (1-4 or 5+) | (Give k | ing | 16b. Kind of Busines | s Industry | | | | | |
| 7 | d withi ygiene her th | Be Co | Elementary/Seconday (0 | Piano Rest | o Restoration/tunin | | | | | | | | | |
| Maryland 21215-0036 | J be filed Jental H Irked ot tic ever | To B | 17. Father's Name (First, Mi Nathaniel Ch | | ser | e (First, Middle, .zabeth | Maiden Surname) Smith | | | | | | | |
| lary | should and N is ma | | 19a. Informant's Name/Rel | |) | - 1 | • | | | ; City or Town, State, 2 | ' ' | | | |
| | and 2 Health em 27 ther to | | Rosemary Was | sser/wife | 100 | 1131 D. Place of Dispos | | | | | ing, MD 20902 | | | |
| mor | age 1 ent of nt: If it ry or o | | 1 ☐ Burial 2 ☒ Crem 4 ☐ Donation 5 ☐ 0 | nation 3 Remova | from State | cemetery, crem | atory or other place) | i | Date //16/12 | 20c. Location - City of Woodbine, | · | | | |
| Baltimore, | permit. F Departm Importal any inju | | 21. Signature of Funeral Se | | 111 | | | | | ce P.O. E Clarksvil | | | | |
| | | | 23a. Part 1. Enter the visea | ase, or complications | that caused the de | | | | | | Approximate | | | |
| - | Physician/ Medical | | shock, or heart failure Immediate Cause (Final disease or condition resulting in death) | a | Alzher | mei | DISEAS | e | | | Interval Between Onset and Death | | | |
| | Examiner | | | | ue to (or as a cons | equence of): | | | | | , | | | |
| | sit sit | Examiner | Sequentially list conditions if any, leading to immediate cause. Enter Underlying | , b | ue to (or as a cons | equence of): | | | | | | | | |
| | ate be executed bhysician and the burial-transit | Exar | Cause (Disease or iinjury that initiated events resulting in death) Last | c | ue to (or as a cons | equence of): | | | | | | | | |
| 09 | te be e nysiciai ne buri | dical | | d | | | | | | - | | | | |
| 687 | artifical ling ph e as th | /Mec | IF FEMALE: | O2a If up | | | | | | | | | | |
| Box (| ath certifica attending p | Physician/Me | 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No | | s, outcome of prec Live Birth 2 F Pregnant at time of | | Ectopic pregnancy Other (specify) | | | 23d. Date of o Month | elivery Day Year | | | |
| O. B | t the de by the tached | hysi | 9 Unknown | 9 🗆 | _ | | | | | | | | | |
| ls, P.O. | s tha igned be de | Completed by F | Part II. Other significant co | onditions contributing | g to death but not | resulting in the ur | derlying cause given in | n Part I. | m | | to the cause of death? Probably 4 Unknown | | | |
| of Vital Records, | aw require as been si 2 should | nplet | Hypstr | Majoria | 7 | | | | 24a. Was a | sy prior to | autopsy findings available completion of cause of | | | |
| Re | sician: The la certificate ha rector, page 2 | | <i>3</i> (| J | | | | | perfor 1 Yes | med? death? | es 2 No | | | |
| /ita | ysician: is certific director, | To Be | 25. Was case referred to me examiner? 1 ☐ Yes 2 ★No | Hospital: | 1 Inpatient 2 | □ EB/Outration | _ Other: | of Death (Check | | - VIII 19 | | | | |
| of | ing Phys fter this ineral di | | 27. Manner of Death | 28a. | Date of injury (Month, Day, Year) | 28b. Time of | 28c. Injury at work? | | | ence 6 Other (Spectrose) ow injury occurred | City Stop (Carry | | | |
| Division | Attendi death ctor: A y the fi | Certificate: | 2 Accident In 3 Suicide 6 (| ovestigation Could not be | Place of Injury - At | home farm stre | | 2 🗆 No | 28f Location (S | treat and Number or P | ural Pouta Number | | | |
| Divi | ital or / irs after al Dire led in b | | 4 Homicide | determined 20e. | building, etc. (Spec | cify) | ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | City or Town | (Street and Number or Rural Route Number, own, State) | | | | |
| 27. Manner of Death The part of the par | | | | | | | | | | nd place, and due to the | cause(s) and manner stated | | | |
| | To the within 2 To the comple | | 29b. Signature and title of co | | 10 0 | | 29c. License nur | | | 29d. Date signed Mon | | | | |
| 0 | | | May | I WY | When l'e | W_ | Kot | 1849 | <u> </u> | 2(15/2 | -12 | | | |
| 17 | \ | | 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Morus Marke Clare (1800 Tech Ed Svike Zife Silve Spring Md | | | | | | | | | | | |
| | Stat Registra | - | 31. Date filed (Month, Day, Y | 1 7 2012 | 32. Postrar's Sig | nature | Med | | | | 2004 | | | |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death -Month [Physician/ male Medical 4a. Facility Name (i not institution, give street and number) 4b. City, Jown, or Location of Death c. County of Death Examiner Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) 220-94-5964 Director 1 🗶 M 2 🗆 F 42 4,1969 AUG. MARYLAND Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland items 23a or 28a-f sho ner must be notified at Director Yes 2 No N/A MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 712 S. CONKLING STREET 21224 U.S.A · death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or iten ledical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give X
Year or Dates. Black, White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 X Divorced Completed and Mental Hygiene.
is marked other than "natural aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) REALTOR REAL ESTATE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 WILBUR **GEORGE** WILLINGER THARESA STOCK 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. THERESA WILLINGER/MOTHER 317 S. FAGLEY STREET, BALTIMORE, MD 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 2/17/12 BALTIMORE, MARYLAND LTLLY ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD Signature of Europa 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of the Ph_sician/ Veno- occlusive disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 the use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death signed by the at Id be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has to the Funeral director, page 2.3 autopsy performed Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No 1 🗌 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Certificate: 1X Natural injury 5 \square Pending Investigation Accident 3 Suicide
4 Homicide 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David LIU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar 04689 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rebel Linn Worm February 0229 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Talbot Easton Memorial Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** Min Hours **Director** 219-62-9510 1X M 2 🗆 F 57 02/27/1955 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Caroline 1 Yes 2 XNo Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5910 Newton Road 21655 USA items ? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 12 Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alga Patricia Towers Earle Burton Worm injury or other traumatic Norm, Aebe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or Shellie Worm Wife 5910 Newton Road Preston MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 02/13/12 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem Glen Burnie MD Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Ser <u>ThomasAllenPA</u> 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ ancer with respiratory disease or condition vecks Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, it at y, leading to in needlate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown igned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? moni 1 ☐ Yes 2 ☐ No 25. Was case referred to medic examiner? 1 Yes funeral director, Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1X Natural 5 Pending 1 Tyes 2 No filled in by the 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature di nd title of certifie 400*9*6873 who completed cause of grath (Item 23a) (Type, Print) Chop tank Community Health 316 Railroad Ave PO Box 122 AnziBEL State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #1 Per Phy G924 2/24/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) **Elizbieta Elizbieta** Bozena 2. Date of Death 3. Time of Death Physician/ February Zelazowska 2012 0800 aMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 14301 Rich Branch Drive N. Potomac 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Country **Director** 62 <u>213–27–9761</u> Jun 9. Poland 1949 Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Montgomery N. Potomac 1 Tes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 14301 Rich Branch Drive USA 20878 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Examiner 14. Bace - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 2**X** No 72 hours after Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 🗆 Widowed 4 🗆 Divorced "natural" Specify: White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any nijury or other traumatic event, the Mea any nijury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Research Scientist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cyprian Kowalczyk Apolonia Kraska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Piotr Zelazowski/husband 14301 Rich Branch Drive N. Potomac, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 02/16/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville. MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ a Non-Hodgkins Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: he law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available 24a. Was an Jas autopsy performer prior to completion of cause of death? the funeral director, page certificate 1 ☐ Yes 2 ☐ No Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 February 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman, M.D. 1355 Piccard Drive Rockville, MD 20850 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year LOUIS B. ANTHONY 6:45 AM 01 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death ANNA POLIS ANNE ANNE ARUNDEL MEDICAL CENTER ARUNDEL 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212 12 3349 Months Min. **Director** 1 **X** M 2 □ F 90 8/22/1921 MD 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director KENT HESTERTOWN MD 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 200 MOUNDA 21620 454 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent Ever III 0.3
Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1943 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) REAL ESTATE BRUKER Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surna 2 HUTHON KYMSEY DUISA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NTHONY JEAN BARBARA 1006 FRANCISCO Cours Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State CHESTER CHESTERTOWN, 28/2012 4 ☐ Donation 5 ☐ Other (Specify) FELL-WS HELFENBEID NELVAN 21. Signature of Fyneral Service Licensee MOX 25 22. Name and Address of Facility 13650272 MARKIN V. WILLIAM. In HESTERT 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

WEKS Immediate Cause (Final Physician/ PANCREATIC CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ABDOMINAL HEMORYHAGE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate Yes I or Attending Physician: after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident iniurv work?
1 Yes 2 No 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse plaqtitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 25 D6675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 arkwar State

DHMH 17 Rev 06-2011

Registrar

68760

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Borowski Leon H. 2012 January 12:08 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1008 Magothy Park Lane Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 15,1929 Birthplace (State or Foreign Country) **Funeral** Days **Director** 214-26-1575 1 ★ M 2 🗆 F 82 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes 2 No Annapolis 10e. Street and Number О 10f. Zip Code 10g. Citizen of What Country? permit, Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 Funeral 1008 Magothy Park Lane 21409 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No 1951. If Yes, Give Year or Dates. 1953 Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White 3 X Widowed 4 Divorced Completed 1953 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Inspector General Motors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Leon H. Borowski, Sr. Eleanor Majeczwski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Graham/Daughter 768 Windgate Drive Annapolis, MD 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Feb. 3 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Veterans Cemetery 2012 Crownsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy. 23a. Part 1 Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between O t and De th Immediate Cause (Final Ph_sician/ disease or condition unita Medical resulting in death) Due to (or as a Examiner Esquentially list sonditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consec or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-tra Due to (or as a consequence resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has filled in by the funeral director, page 2 autops erform certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 L Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 12

State Registrar Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-00861 Donna Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 04693

| | | - For State egistrar | | Cert | ificate of | Death | | | Reg. N | | | | |
|--|---|---|---|---|----------------------------|---------------------------|--------------------------------------|--|---|--|---|--|--|
| Physiciar | 1/ | . Decedent's Name (First, Middle,La | st) | | " . | | | 2. Date of Month | | | 3. Time of Death 1106 hrs | | |
| ledical Examin | | Donna Brown | | | | 01 T | | | Month Day Year 1106 hrs 4c. County of Death | | | | |
| | 1 | ta. Facility Name (if not institution, gi Anne Arundel Medical Ce | | | 4 | Annapo | wn, or Location o | | | Anne Arundel | | | |
| Funeral Director | , | 5. Social Security Number 6. \$ 214–17–6694 | 7. Age M 2X F | e (In yrs. las 27 | | If Under Months | 1 Year If Unde Days Hours | 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD | | | | | |
| | ŀ | Usual Residence of Decedent | | | | | | | | | | | |
| I sow any | | MD Anne Ar | undel | , | own or Location erna Pa | | | | | | 10d. Inside City Limits 1 Yes 2 No | | |
| aryland Sa-f show at once. | Director | Oe. Street and Number | ander | 501 | | 10f. Zip C | ode | | 10g. (| Citizen of What Coun | try? | | |
| th the Maryland 23s or 28s-f sho motified at once | | 303 Gordon Avenu | е | | | | 21146 | | | USA | | | |
| E S | | 11. Marital Status 1 X Never Married 2 Marrie | 12. Was Decedent Armed Forces? | | i. 13. Was | Decedent es, specify | of Hispanic Orig Cuban, Mexican, | in? (Specify Yes Puerto Rican, et | or No- c.) | 14. Race - Americ White, etc. | | | |
| after d | <u>8</u> | | d If Yes, Give Year or Dates: | | | | No specify: | | - 1.0 | Specify: Whi | | | |
| hours natur | | 15. Decedent's Education (Specify | | | 16a. Decedent during mo | 's Usual O st of worki | ccupation (Give I ng life. DO NOT | kind of work done use retired) | 116 | b. Kind of Business/Ir | ndustry | | |
| 5-0036 ted within 72 hours tygiens other than "natur the Medical Exami | Completed | Elementary/Secondary (0-12) | College (1-4 or 9 | , | | Stu | dent | | | Col | llege | | |
| 21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than te event, the Medica | ទី | 17. Father's Name (First, Middle, Las | | | | | | 's Name (First, Mi | | den Surname) | | | |
| 2121 uld be fil Mental I marked | 99 0 | Michael Murray Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, | | | | | | | | | | | |
| MD 2 d 2 shoul th and M n 27 is n | Ĕ | 19a. Informant's Name/Relationship (Type, Print) Diane Brown/Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta | | | | | | | | | | | |
| imore, MD 2 Pages I and 2 shou nent of Health and In lant: If item 27 is no or other tranmatic | - 1 | 20a. Method of Disposition 1 X Burial 2 Cremation 3 | _ | lace of Disposi ematory or oth rraine | | | Feb. 3 | | Oc. Location - City or Town, State Baltimore, MD | | | | |
| Pages Pages nent of ant: I | | 4 Donation 5 Other Specific | y: / | TO | | | | 2012 | | | | | |
| Baltimore, MD ; permit. Pages I and 2 shon Department of Health and Important: If item 27 is injury or other fraumatining. | 21. Signature of neral Service gicens 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park 495 Ritchie Hwy. Severna Park, | | | | | | | | | | neral Home D 21146 | | |
| Physician | 4 | 23a art I. Er ter the disease, or co- failure. Li t only one cause of | pi tions that caused ch line. | the death. | Do not enter th | e mode of | dying, such as c | ardiac or respirat | ory arrest, | shock, or heart | Approximate Interval Between Onset and | | |
| /Medical | X | / | Pulmonary Thro | | | | | | | | Death | | |
| | (| | Due to (or as a cons | | | nbosis | | | | | | | |
| | ine. | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | Due to (or as a cons | equence of) | t | | | | | | | | |
| ansit | Exa | events resulting in death) Last | Due to (or as a cons | equence of) |): | | | | | | | | |
| 760, crate be executed physician and the burial - transit | Medical | UNPENDED AMENDED | | | | | | | | | | | |
| certificate by | | IF FEMALE: 3b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome 1 Live birth | me of pregn | | al death | 3 Ectopio | c pregnancy | | 23d. Date of delivery Month | y Day Year | | |
| Box 687 e death certific the attending i | Physician | 1 Yes 2 No 9 V Unknow | 4 Pregnant at 9 Unknown | time of dea | ath 5 Otl | ner (Speci | fy) | | - | | | | |
| P.O. B as that the de igned by the detached is | | Part II. Other significant condition | contributing to deat | h but not re | sulting in the u | nderlying | cause given in Pa | | | cco use contribute to | the cause of death? | | |
| w requires to been sign should be | | | | | | | | 248 | . Was an | | topsy findings available | | |
| COFC te law re te has be | Completed by | | | | | | | — ₁√ | autopsy performe Yes 2 | | completion of cause of | | |
| Vital Rec ysician: The I his certificate I director, page | | 25. Was case referred to medical | | | | 20 | | (Check only one) |) | | | | |
| Vita | 10 Be | examiner? | Hospital: 1 Inpatie | | ER/Outpatient | | | | | sidence 6 Other | 1 | | |
| in of iding Pl | | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Inji (Month, Day,) | ury Year) | 28b. Time of I | njury 28 | 3c. Injury at Work | . I | scribe how | v injury occurred | | | |
| O 1 1 1 1 2 Accident Investigation | | | | | | | | | | ral Route Number, City | | | |
| 3 Suicide 6 Could not be determined (Specify) 3 Suicide 6 Could not be determined at the time, date and place, and due to the cause(s) and manny (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manny (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manny (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manny (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manny (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manny (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manny (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manny (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place. | | | | | | | | | | s) and manner as state | ed. | | |
| To the within 2 To the complet | Medical | one) 2 Medical Examin | er:On the basis of exa and manner stated | amination an | nd/or investigat | | | | | | | | |
| | Ž | 29b. Signature and title of certifier | 1 11 | 29c. License number O.C.M.E. | | | | | | 9d. Date signed (Mo. January 30, 2012 | | | |
| | - | 30. Name and a toress of person with | o completed calle of sistant Medical E | | | Raltimor | Street Ralt | imore MD 2 | 1223 | | | | |
| HU Sta | ate | Zabiullah Ali, M.D. As 31. Date filed (Month, Day, Year) FER 02 | | -1-0:1 | | | | | | | | | |
| Regist | 110 | CED (19) | 2012 /2 | | A. de | a Kal | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2012 MARY FRANCES BIDDINGER РМ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min Director 1 M 2 X F 218-32-9010 18 1936 Marvland 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5605 Bartonsville Road 21704 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 11 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Francis William Wagner Evelyn May Rinehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other tran Ray Grayson Biddinger/ Husband 5605 Bartonsville Road, Frederick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/02/2012 Olivet Frederick, Maryland permit. 21. Signature of Funeral Service 22. Name and Address of Facility
Robert E. Dailey & Son Funeral Homes,
1201 North Market St., Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final SUDDEN Onset and Death DEKTH Physician Medical resulting in death) Due to (or as a consequence of) Examiner chuhle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform after death.

Director: After this certificate 2 No 21 No Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2X No Certificate: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 1-X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 009689 30/12 GITT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 A Stir 31. Date filed (Month, Day,) Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Virginia Barrow Baker 2012 5:42 J<u>anuary</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Perryville Cecil 455 Franklin Street 5. Social Security Number If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) If Unde 1 Year Hours 216-20-3411 Director 1 □ M 2 🗓 F 86 1925 Dec. 17. Maryland Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Ceci1 Perrvville 1 X Yes 2 No Maryland ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21903 455 Franklin Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced Specify: Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Harford Memorial Hospital if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Medical Transcriber Eleven Years Havre de Grace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Viola Merrick John T. Barrow, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 445 Franklin Street, Perryville, MD Page 1 and 2 Doris B. Sinclair (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o of 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 02/01/12 Perryville, Maryland Principio Cemetery 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, 21. Signature of Funeral Service Licensee Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line ediate Cause (Final Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12-months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the sause of death? ģ 1 Tes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 🗌 Yes 2 🔀 No 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 No 1 🗌 Yes Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred J Natural 5 Pending work?
1 Yes Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 2 🗆

Records, Division of Vital 24 hours after deat Funeral Director: within 24 hou To the Fune completely fi

Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 31. Date filed (Month, Day, Year) State Registrar

only one)

29b. Signature and title of certifier

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\text{February}^{\text{Month}}\text{2}$ 20ÏŽ Irene Joan Bramble 8:30 a. M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mallard Bay Care Center Cambridge Dorchester Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ct. 28 1 M 2 F Months Days Hours Min Maryland 220-36-3464 73 Oct. Director Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f show 10a. State 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director MD Vienna Dorchester 1 Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21869 5136 Rhodesdale Vienna Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white If Yes, Give 3 ▼ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) billing clerk hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Cleveland Carneal Mary Maloney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3617 Cinnamon Lane, Linkwood, MD 21835 Judy Wingate daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Crematory of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) 2/3/12 Delmar, DE 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STA RE DEMENTIA. KHO disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death the i 9 Unknown 9 Unknown s been signed by should be detact Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 sl autopsy certificate ! 2 N director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending work? 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar BYRN STREET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

603

Registrar's Signa

ERRABOLU

JEEVAN

31. Date filed (Month, Day, Year)

FEB 03

D69234

CAMBRIDGE

2012

21613

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Testate 2/7/2012 AACO HEALTH DEPT ONH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ S. Clark Irma 2012 January 9:58 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 611 Bay Hills Drive Arnold 212-36-4220 Der 212-30-4270 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year) Feb. 12, 1921 90 Director 1 □ M 2 🗓 F Germany 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director notified MD Anne Arundel Arnold 1 Yes 2 X No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ber "natural", or items 23a 21012 611 Bay Hills Drive USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Department of Health and Mental Hygiene-Important: If item 27 is marked other than any injury or other traumastics Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Katharine Wehrum Heinrich Sann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Bay Hills Drive Arnold, MD 21012 Lisa Perkins / Daughter Date 01, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. Davidsonville, MD 4 Donation 5 Other (Specify) 2012 22. Name and Address of Facility Barranco & Sons, P.A. 495 Ritchie Hwy, 21. Signature of Funeral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ umon disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and -transit that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the burialphysiciar Physician/Medical as t nse (23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 51169 31/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4201 Mitchelhille Rd #102, Bowie, MD 20716

DHMH 17 Rev 06-2011

State Registrar

Box 68760

P.O.

Records,

Division of Vital

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| | | For State Registrar | State | of Marylar | | artment of F <i>tificate of E</i> | | d Mental Hy | giene Reg. No. | 20 | 12 | 01699 | |
| Physicia | n/ | 1. Decedent's Name (First, Middle | · · | | | | | 2. Date of De | eath | | Year | 3. Time of Death | |
| Medic Examin | al | GEORGE LAFA 4a. Facility Name (if not institution | | mber) | III | 4b. City, Town, or | Location of De | JANUARY | | , 20 | | 10:09 A | |
| . * | | MEMORIAL HOSP | | | | EASTON | | | Т | 'ALBO | T | | |
| Funeral Director | | 5. Social Security Number 063-40-5942 | 6. Sex 1 X M 2 □ F | 7. Age (In yrs. | 63 Yrs. | If Under 1 Year Months Days | If Under 24 H Hours M | 1rs. 8. Date of Bir lin. (Month, Da 04/15/ | v Year) | | Count | lace (State or Foreign ry) SYLVANIA | |
| land show dat | | Usual Residence of Decedent 10a. State 10b. County | / | 10c. Cit | ty, Town or Lo | cation | | | | | 10 | Od. Inside City Limits | |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral Director | MD QUEEN 10e. Street and Number | ANNE'S | СНІ | ESTERTO | 10f. Zip Code | | | 10 0" | | | 1 🗆 Yes 2 💢 No | |
| with the s 23a o | eral | 221 OLD BRIDG | E ROAD | | | 21620 | 0 | | 10g. Citizen of What Country? UNITED STATES | | | | |
| r death rritems inerm | | 11. Marital Status 1 □ Never Married 2 【 Mar | Armed F | | | | spanic Origin? | (Specify Yes or No- erto Rican, etc.) | | 14. Race - Black, | - America White, e | | |
| ırs after ural", o I Exam | ted by | 3 Widowed 4 Divorced | If Yes, G | 2 □ No ive Dates. 1968- | -70 | ∏ Yes 2 X No | Specify: | | | Specify: WHITE | | | |
| 72 hou n "nati Aedica | Completed | (Specify only high | ent's Education est grade completed | | (Give | dent's Usual Occupa kind of work done d O NOT use retired) | | vorking | 16b. Ki | Kind of Business Industry | | | |
| within ygiene. | | Elementary/Seconday (0-12) | | 1-4 or 5+) 2 | | IMPROVEM | ENT | | CON | STRU | CTIO | N | |
| be filed ental Hy ked otl | To Be | 17. Father's Name (First, Middle, | , | TD | | | | Name (First, Middle, | Maiden S | faiden Surname) | | | |
| should and Me is marl | | 19a. Informant's Name/Relations | | , JK. | 19b. Mailir | ng Address (Street a | | A COWAN Rural Route Number | er, City or | ity or Town, State, Zip Code) | | | |
| and 2 s Health em 27 ther tra | | PATRICIA CONDICATION 20a. Method of Disposition | r / WIFE | 20h I | | | E ROAD | CHESTERTO | | | | | |
| Page 1 nent of int: If it ry or o | | 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other 6 | | n State | cemetery, crer | sition (Name of natory or other place E CREMAT | 4 | Date 28/2012 | | cation - C | - | , MARYLAND | |
| ermit. I Departm mporta Iny inju | | 21. Signature of Funeral Service | | | 22 | Name and Address | s of Facility | IN & NEWN | | | | | |
| 10 1 | | 23a. Part 1. Enter the disease, o | r mplications that | caused the deat | 113 | O SPEER | ROAD CH | ESTERTOWN | I, MA | RYLA | ND 2 | 1620 Approximate | |
| Physician/ | , (| shock, or heart failure. List Immediate Cause (Final disease or condition | Res | hipate | m-Fa | ilure au | od Hyr | poxia | | | | Interval Between Onset and Death | |
| Medical Examiner | | resulting in death) | Due to | (or as a consequent | uelice of): | 5040 | 10 T 4 2 | TO DAN. | 7 | | | | |
| | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Distributed of the property of t | | | | | | | | | | | |
| executed an and ial-transi | Examiner | Cause (Disease or iinjury that initiated events resulting in death) Last | c. Rigi | of or as a consequence | uence of): | wal To | MOR (| POORLY DI | Frek | entra | ed | | |
| ra a e | _ | , | L _{d.} | | <u> </u> | | | (Arcinoma) | | | | | |
| eath certificat attending ph I for use as th | | IF FEMALE: | 23c. If yes, or | itcome of pregna | ancv | | | | T | | | | |
| death c | siciar | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | 1 Live | Birth 2 🗀 Feta gnant at time of | al death 3 | Ectopic pregnanc Other (specify) | у | | 23d. Date of delivery Month Day Year | | | | |
| nat the derect by the a | F. | 9 ☐ Unknown Part II. Other significant condition | | | sulting in the u | nderlying cause giv | en in Part I. | 23e. Did tobacco use contribute to the cause of o | | | | | |
| requires that been signed t should be det | Completed by | CHRONIC TOB | ACCO US | ~e | | | | 1 🗨 | Yes 2 | □ No 3 | ☐ Prob | ably 4 🗌 Unknown | |
| law rec has bee e 2 sho | nplet | | | | | | | 24a. Was | psy | sy prior to completion of cause of | | | |
| Physician: The law I r this certificate has t rral director, page 2 s | | 25. Was case referred to medical | | | | 26 Dia | ace of Death (C | 1 Tes | ormed? 2 No | | ath? Yes 2 | 2 No | |
| hysicia his cert I direct | To Be | examiner? 1 Yes 2 No | | Inpatient 2 | ER/Outpatier | Otho | r: | g Home 5 Resid | dence 6 | Other | Specify) | | |
| Te fe | cate: | 27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi | ig . | e of injury nth, Day, Year) | 28b. Time of injury | 28c. Injury work' M 1 🗆 | | 28d. Describe h | now injury | occurred | | | |
| Hospital or Attendii 24 hours after death. Funeral Director: Al eted filled in by the fu | Certificate: | 3 Suicide 6 Could 4 Homicide determ | not be 28e. Place | e of Injury - At ho ling, etc. (Specif) | ome, farm, stre | eet, factory, office | | 28f. Location (\$ City or Tow | (Street and Number or Rural Route Number, | | | | |
| To the Hospital or Atte within 24 hours after de To the Funeral Direct completed filled in by the | | 29a. Certifier 1 Certifying | Physician: To the | best of my know | ledge, death o | occured at the time | date and place | | | d manner: | as stated | | |
| the Ho hin 24 h the Fui npletec | Medical | (Check 2 Medical I | Examiner: On the ba | sis of examination | n and/or invest | igation, in my opinio | n, death occurre | ed at the time, date a | and place, | and due to | the caus | se(s) and manner stated. | |
| So d with | - 1 | 29b. Signature and title of certifie | A.O a. | 211 | | 29c. License | number | | 29d. Date | e signed (/ | Month, D | ay, Year) | |
| 11 | ŀ | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70hw C - HRRBALTH H. D. 223 Helph Street (User tenther) 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | | | | | | | | | |
| 2 In State | | VOIN C - ARR 31. Date filed (Month, Day, Year) | ABALV. | Registrar's Signa | . 223 | High Str | RET, CH | in fir tau | n | ma | . 2 | 1620 | |
| Registra | ır | 31. Date filed (Month, Day, Year) | 30 2012 | Consultant . | A. 1 | grand. | | | | | | | |

Registrar DHMH 17 Rev 7/2009

| | | | State of Mar | | | | | | | regible. | | | | |
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| | - | For State Registrar | | , | | tificate of L | | | Reg. No. | 2012 | 04700 | | | |
| Physiciar | , | 1. Decedent's Name (First, Middle, La | st) | | | | | 2. Date of De | eath Day | Year | 3. Time of Death | | | |
| Medica | al | ETHEL PAULA HATCH 4a. Facility Name (if not institution, give | | NGHAI | M | # 0" T | | JANUAI | RY 26 | , 2012 | 2:30 A M | | | |
| Examine | ∍r | 8579 CAMP ROAD | e street and number) | | | 4b. City, Town, or CHESTER | | atn | | 4c. County of Death KENT | | | | |
| Funeral | | 5. Social Security Number 6. S | Sex 7. Age (i | ln yrs. last i | | If Under 1 Year Months Days | If Under 24 H | n. (Month. Da | th av. Year) | 9. Birl | thplace (State or Foreign | | | |
| Director | | 218-40-7118 Usual Residence of Decedent | L W 2 41 | 70 | Yrs. | | | Min. (Month, Day, Year) Country) 10/07/1941 MARYLAND | | | | | | |
| rland f shov | ģ | 10a. State 10b. County | 1 | Oc. City, To | own or Loc | ation | | | | | 10d. Inside City Limits | | | |
| e Mary r 28a- notifie | Sire | MARYLAND KENT 10e. Street and Number | | CHEST | ERTOW | | | | | | 1 🗆 Yes 2 🛣 No | | | |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral Director | 8579 CAMP ROAD | | | | 10f. Zip Code 21620 | | | | zen of What Co ED STAT | | | | |
| items | | 11. Marital Status | 12. Was Decedent Eve Armed Forces? | er in U.S. | 13. W | | ispanic Origin? | (Specify Yes or No- | - | 4. Race - Ame | rican Indian, | | | |
| after or xamir | d b | 1 ☐ Never Married 2 K Married 3 ☐ Widowed 4 ☐ Divorced | 1 Yes 2 X No | 0 | | ☐ Yes 2 X No | | 3101110411, 010.7 | | Black, White Specify: | | | | |
| hours natura lical E | lete | 15. Decedent's I | | 6a. Deced | ent's Usual Occup | ation | 1 | WHITE 16b. Kind of Business Industry | | | | | | |
| nin 72 ne. han "l e Med | Completed | (Specify only highest g. Elementary/Seconday (0-12) | rade completed) College (1-4 or 5+) | | (Give k life. DC | ind of work done of NOT use retired) | luring most of w | vorking | | | • | | | |
| ed with Hygien Sther I | Be C | 12 17. Father's Name (First, Middle, Last) | | L. | EGAL | SECRETAR | | lame (First, Middle, | LEG Maiden S | | | | | |
| l be file fental rked c | ءِ | ROBERT ROGERS HA | | R. | | | | TTE ANN | | | | | | |
| should and N is ma auma | | 19a. Informant's Name/Relationship (| | | 19b. Mailin | g Address (Street | | Rural Route Numbe | | | Code) | | | |
| and 2 Health em 27 ther tr | | JESSE CUNNINGHAM 20a. Method of Disposition | / HUSBAND | | | CAMP ROA | D CHEST | ERTOWN, | | | | | | |
| age 1 ent of I nt: If its y or o | | 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec | | ceme | etery, crem | atory or other plac | | Date | | cation - City or | | | | |
| mit. P. partme portar / injur | ł | 21. Signature of Funeral Service Licen | | ST. | 22. | 'S CEMET | ss of Facility | | | | N, MARYLAND | | | |
| B I De | _ | Keil & He | Galen | | FE 13 | LLOWS, H O SPEER | ELFENBE ROAD CH | 1N & NEWI ESTERTOWN | NAM F N. MA | UNERAL RYLAND | HOME, P.A. 21620 | | | |
| | | 23a. Part 1. Enter the disease, or conshock, or heart failure. List only | one cause on each line. | | | | | | | • | Approximate Interval Between Onset and Death | | | |
| Physician/ Medical | | Immediate Cause (Final disease or condition resulting in death) | a. Due to (or as a c | 454 | ATIO | C BRE | AST | CANCE | -12 | | 2 years | | | |
| Examiner | | Conversion, link and Miner | b | onocquone | oc 01). | | | | | | | | | |
| , ii | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a c | consequenc | ce of): | | | | | | | | | |
| be executed sician and burial-transit | Exa | Cause (Disease or iinjury that initiated events resulting in death) Last | c. Due to (or as a c | onsequenc | ce of): | | | | | | | | | |
| be e | <u>ca</u> | | d | | | | | | | | | | | |
| rtificat ing ph e as th | Physician/Med | IF FEMALE: | | | | | | | | | | | | |
| ath ce attend for us | cian | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti | Fetal de | eath 3 🗌 | Ectopic pregnand Other (specify) | :y | | 2 | 3d. Date of del Month | livery Day Year | | | |
| the de | hysi | 1 | g 🗌 Unknown | | | | | | | | | | | |
| requires that the death certificate been signed by the attending phys should be detached for use as the | ≥ | Part II. Other significant conditions | contributing to death but | not resultir | ng in the ur | nderlying cause giv | en in Part I. | | | , | the cause of death? | | | |
| require | Completed | | | | | | | - 1 L | | | robably 4 Unknown | | | |
| rsician: The law socrtificate has the sirector, page 2 s | dwc | | | | | | | 24a. Was auto perfe | psy ormed? | prior to death? | topsy findings available completion of cause of | | | |
| ian: Tr | Be C | 25. Was case referred to medical examiner? | | _ | | 26. Pl | ace of Death (Ca | 1 ☐ Yes heck only one) | 2 No | 1 Yes | 2 X No | | | |
| hysic this ce | ₽ | 1 Yes 2 No | Hospital: | | | | 4 L Nursing | Home 5 Resi | dence 6 | Other (Spec | ify) | | | |
| ding F th. After funera | cate | 27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident Investigation | 28a. Date of injury (Month, Day, Y | | b. Time of injury | 28c. Injury work M 1 🗆 | | 28d. Describe | how injury | occurred | | | | |
| Atten er dear ector: by the | Certificate: | 3 Suicide 6 Could not I | 28e. Place of Injury | | , farm, stre | | 103 2 1140 | | 28f. Location (Street and Number or Rural Route Number, | | | | | |
| urs after ral Dir | | 0 | building, etc. (| | | | | City or Tou | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the | Medical | (Check 2 \(\sum \) Medical Exam | ysician: To the best of my niner: On the basis of example of the best of the b | mination an | d/or investi | gation, in my opinio | n, death occurre | ed at the time, date | and place, | and due to the o | cause(s) and manner stated. | | | |
| To the within To the compl | — r | only one) 3 L Certifying Nui 29b. Signature and title of certifier | rse Practioner: To the be | nstormy kn | owieage, d | eath occurred at the 29c. License | | prace, and due to the | | and manner as e signed (Month | | | | |
| 15 | | > tuk | t/Whe | e V | w | 100 | 0415 | 87 | / | 126 | 12012 | | | |
| RM | | 30. Name and address of person who | completed cause of dear | th (Item 23: | a) (Type, Pr | Chest. | PA LI | m MD | 7 | 1020 | | | | |
| State | 9 | 31. Date filed (Month, Day, Year) | 32. Registrar's | Signature | 1111 | barto | OL 10 M | I IVID | - | 1020 | | | | |
| Registra | - | 2494 3 | n onto b | - | p. | 1 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAE COLEMAN 2 6 12 1:00 AURA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Monyland University Raltimore Rastinore Œ Social Security Number If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday, 24 Hrs. **Funeral** Months Hours Director 216-64-8488 1 M 2 X F DELAWARE 05/27/1963 48 Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified a 1 XYes 2 No CALVERT ST. LEONARD MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be r Funeral 20685 4226 ST. LEONARD ROAD UNITED STATES items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. "natural", or i þ 1 Never Married 2 Married within 72 hours after Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working i other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Hitem 27 is marked of other traumatic ever ၉ ETTA MASTEN RICHARD MURPHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVE COLEMAN / HUSBAND 4226 ST. LEONARD ROAD ST. LEONARD, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ō = 5 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) CHESAPEAKE CREMAITON 01/30/2012 STEVENSVILLE, MARYLAND Signature of Funeral Service Licer FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, Buch 30 SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Subarachnoid hemosshare Medical resulting in death) Due to (or as a consequence of): Examiner days coaculo patin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events unknow Star as the burial-trar and Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical unujow death certificate be alcohol abuse P.O. Box 68760 IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No ed by the a detached f 9 Unknown signed by t Id be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given'in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Director: After this certificate 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner? ٩ 2 000 Other: 1 Yes 1 Papatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town. State within 24 hours a

To the Funeral D

completely filled the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day. Year) 01/24/2012 8 and address of person who completed cause of death (Item 23a) (Type, Print) INS Charatte KVASNOV 22 South Baltmor, NB 21201 SKL Green strar's Signature 31. Date filed (Month, Day, Year) State 26/2012 Registrar

| | | | Please | Type or P | | | | | | | | | ble. | | |
|--|---|--|--|--|--|------------------------------|--|-------------|--------------------------------------|-----------------------------------|-----------------------|----------------------|-----------------------|--------------------------------|------------------|
| | | For State | | State of | Marylar | | artment o <i>tificate o</i> | | | Лental Нус | | 00 | 1.0 | 01" | 7 0 2 |
| | | Registrar 1. Decedent's Nam | ne (First, Middle, La | est) | | 007 | tinoate o | | atti | 2. Date of Dea | Reg. No ith | 20 | 12 | 3. Time of I | Death |
| Physicia Medio | | A1ma | G. Cla | y | | | | | | January | y 29 | y 20 | Year 12 | 11:10 | \mathbf{P}^{M} |
| Examin | er | 4a. Facility Name (if | f not institution, giv | e street and numbe | r) | | | | cation of Death | | 40 | . County o | f Death | | |
| Funeral | | Glade V 5. Social Security N | Valley lumber 6.5 | Sex 7. | Age (In vrs. | last birthday) | If Under 1 Ye | | ersvill f Under 24 Hrs. | e 8. Date of Birtl | h | | | derick lace (State or | Foreign |
| Director | | 219-20-11 | | 1 □ M 2 □ X F | 84 | Yrs. | Months Da | /S F | Hours Min. | (Month, Day | , Year) | _ | Count | ry) | roreign |
| nd how at | Ļ | Usual Residence of | of Decedent 10b. County | | 10c. Gi | ty, Town or Lo | cation | | | Feb.18, | ,192 | 7 1 | /irg | inia Od. Inside City | v Limite |
| with the Maryland 23a or 28a-f show st be notified at | ecto | Maryland | Freder | ick | | , | larket | | | | | | | 1 \(\text{Yes} | |
| a or 2 | ٥ | 10e. Street and Nur | | I CI | | 2.07. | 10f. Zip Cod | е | | | 10g. Cit | tizen of Wh | | try? | |
| after death with the Maryland I", or items 23a or 28a-f sho xaminer must be notified at | Funeral Director | | agertown | | | | 21774 | | | | | USA | | | |
| er death w or items ? miner mus | by Fu | 11. Marital Status | ied 2 🕅 Married | 12. Was Deceder Armed Force 1 Yes 2 | \$2 | | | | anic Origin? (Spe Mexican, Puerto | ecify Yes or No- Rican, etc.) | | 14. Race - Black, | - America White, e | | |
| ırs afte ıral", | | 3 Widowed | | If Yes, Give Year or Dates | | 1 | 1 ☐ Yes 2 🔀 No Specify: | | | | | Specify: | Wh | ite | |
| 72 hou "natu edica | Completed | (Spe | 15. Decedent's lecify only highest g | | - | (Give I | cedent's Usual Occupation ve kind of work done during most of working | | | | | ind of Bus | iness/Inc | lustry | |
| vithin intene. r than | Con | Elementary/Second 12 | ondary (0-12) | College (1-4 | or 5+) | | DO NOT use retired) tch Board Operator | | | | | Teler | hone | Compa | iny |
| filed wall Hyg | Be | 17. Father's Name (| First, Middle, Last) | | | 1 0 11 20 | JII 2041 | | | e (First, Middle, I | | | | | |
| uld be Ment narked | To | | A. Rain | | | | | I | Ethel Re | eed | | | | | |
| permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar once. | | 19a. Informant's Name/Relationship (Type, Print) Albert Clay / Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 5720 Yeagertown Road, New Market, MD 21774 | | | | | | | | | | | | | |
| ye 1 ar it of He If iten or oth | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 2/1/2012 3 3 3 3 3 3 3 3 3 | | | | | | | | | | | | • | wn, State | , |
| nit. Pag artmen ortant injury | | 4 ☐ Donation 21. Signature | 5 Other (Spec | ify) | St | | Cremat Name and Ad | _ <u> </u> | 1 | | | | | lary1ar | 1a ——— |
| Depar Impo any ir | | 57 | 1 Anul | Star | 111. | _ | | | • | Stauf Pike, F | | | | |) |
| | | 23a. Part LEnter to shock, or hear | he disease, of com rt failure. List only o | plications that can | ed the deat | th. Do not ente | | | | | | 01201 | | Approximate Interval Betw | |
| Physician/ Medical | | Immediate Cause (disease or conditio resulting in death) | Final | a. Cer | elmo | Vase | | | uden | | | | - | Onset and De | |
| Examiner | iner | | | Due to (or a | is a consequence of the conseque | uence of): | wn | | | | | | | Jeans | |
| - # | | Sequentially list con if any, leading to im- cause. Enter Under | nditions, nmediate riving | b. Due to (or a | s a conseq | uence of): | | | | | | | | , | |
| executed an and ırial-transit | Examiner | Cause (Disease or i that initiated events | injury s | C. Due to (or s | o consequ | uence of | | | | | | | _ | | |
| be exe sician | _ | | | | | | | | | | | | | | |
| ficate g physas the | /ledi | d | | | | | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian | Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal death 5 Other (specify) Month 9 Unknown 1 Unknown 23d. Date of Month Month | | | | | | | | | | | delivery Day Year | | |
| requires that the de been signed by the should be detached | by Ph | Part II. Other signifi | icant conditions | contributing to deat | but not res | sulting in the u | nderlying cause | given i | in Part I. | 23e. Did tol | bacco u | se contrib | ute to the | e cause of dea | ath? |
| quires en sig ould b | | | | | | | | | | 1 🗆 Y | es 2 | No 3 | ☐ Prob | ably 4 🗌 U | nknown |
| law re nas be e 2 sh | Completed | | | | | | | | | 24a. Was a | sy | prie | or to con | sy findings av | |
| sician: The law is certificate has k | | 05.144 | | | | | | | _ | perfor | med? 2 X No | dea 1 | ath? Yes 2 | 2 No | |
| ysician: is certific director, | o Be | 25. Was case referre examiner? 1 ☐ Yes 2 🗑 | | Hospital: | | | | ther | of Death (Check | | | | | | |
| g Phy er this neral c | te: To | 27. Manner of Death | 1 | 28a. Date of in (Month, I | njury | ER/Outpatien 28b. Time of | 28c. In | ury at | | me 5 Reside 28d. Describe ho | | | (Specify) | | |
| tendin leath. or: Aft the fu | ifica | 1 ∰Natural 2 ☐ Accident 3 ☐ Suicide | 5 ☐ Pending Investigatio 6 ☐ Could not b | n | Jay, rear) | injury | | ork? Yes | 2 🗆 No | | | | | | |
| To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Il Certificate: | 4 Homicide | determined | 28e. Place of I | njury - At ho etc. <i>(Specif</i>) | | et, factory, offic | е | | 28f. Location (St City or Towr | | Number o | or Rural F | Route Numbe | ŗ |
| e Hospi 124 hou e Funer | Medical | (Check 2 | | sician: To the best inor: On the basis o se Practitioner: To | f examinatio | n and/or investi | igation, in my op | inion, d | leath occurred at | the time, date an | d place, | and due to | the caus | se(s) and mann | ner stated. |
| To th withir To th comp | | 29b. Signature and t | title of certifier | 2 | - | | | | | | | | | | |
| \9 | | 30. Name and addre | ess of person who | completed cause o | death (Item | 1 23a) (Type, Pi | rint) | 43 | 21 21 | onse | 1^ | 200 | 201 | | |
| State | | 31. Date filed (Month | | Ceria, | trar's Signa | ture | 801 | 10 | LL AT | use | DV | e, | fre | COVIC | カワ |
| Registra | ır | - | LER O I S | 2012 | BRAN | D. A. | ares | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DWIN 2303 anuary Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** HOPKINS the Johns Timore Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Sept. 5,1995 New York Director 046-94-8543 1 **X** M 2 \square F 16 show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director "natural", or items 23a or 28a-f dical Examiner must be notified MD Talbot Trappe 1 Yes 2 No 10e. Street and Number 10f. Zip Code and 2 should be filed within 72 hours after death with the 10g. Citizen of What Country? Funeral 29793 Bolingbroke Point Drive 21673 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Completed by Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natur any injury or other traumatic event, the Medical Lonce. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) student school Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert N. Cowin Laura Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert N. Cowin father 29793 Bolingbroke Point Dr., Trappe, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Crematory of Delmarva 2/2/12 Delmar, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. re of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 L Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: ျှ 1 L Yes 1 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident 1 Yes 2 No Investigation completely filled in by the 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St. Baltimore MD 21287 Andrew anasolon 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician McGlaughlin Creighton February 12:10 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester General Hospital Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 x M 2 □ F 218-12-4121 87 March 23,1924 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be natified at MD Director Dorchester Church Creek 1 ☐ Yes 2 👿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4665 Golden Hill Road 21622 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after lealth and Mental Hygiene. m 27 is marked other than "natural", or ite 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No white ģ If Yes, Give Year or Dates: WWII Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) salesman metal belt mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Menta Earl Creighton Margie McGlaughlin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly N. Creighton p.r. 4663 Golden Hill Road, Church Creek, MD 21622 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Old Trinity Churchyard 2/3/12 4 ☐ Donation 5 ☐ Other (Specify) Church Creek, MD 22. Name and Address of Facility Thomas Funeral Home P.A. re of Funeral Service Licensee 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the use as IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. I ed by the a detached f Tyes 2 No 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ COPD 1 ☐ Yes No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ၉ 2√No 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Mann of Death Certification: 28d. Describe how injury occurred Injury at Work? Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar BYRN

31. Date filed (Month, Day, Year)

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

CAMBRIDGE

ORIGINAL

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Felomasi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 05

| / Wayne Davi | | I- For State | Sta | ate of | Maryla | | artment of rtificate of | | and | Menta | al Hyg | | | | 1 4 | . 0410 | |
|--|----------------|---|---------------------------------|-------------------|---|----------------------------------|--------------------------------------|--|-------------------|-------------------|-----------|-------------------------------|------------------|-----------------------------|--|--|--|
| Physician | | Registrar 1. Decedent's Nam | ne (First, Middle | e,Last) | | C E. | Timeate of | Deau | | | 2 | . Date of Dea | leg. No ath |). | Т | 3. Time of Death | |
| cal Examine | - | Terry Wa | | | | | | | | | | Month January 2 | | | | 0421 hrs | |
| | | 4a. Facility Name (Anne Aruno | | - | | imber) | | b. City, To | | ocation of | Death | | | c. County of D Anne Arun | | | |
| Funeral | 4 | 5. Social Security N | | 6. Sex | | 7. Age (In yrs. | last birthday) | If Under | | If Under: | 24Hrs. | 8. Date of Bi | rth(MN | //DD/YYYY) 9 | . Birth | place (State or | |
| Director | | 219-64-0 | 10.00 | 1 X M | 2F | | 55 Yrs. | Months Days Hours Min. Mar 25 1956 Foreign | | | | | | 100 | | | |
| _ | - | Usual Residence o | | | | Lia an | | | | | | | | | | 10d. Inside City Limits | |
| ow any | | 10a. State MD | 10b. County | Anı | ındel | | , Town or Locati everna P | _ | | | | | | | | 1 Yes 2 X No | |
| the Maryland or 28a-f sh iffed at once | 3 | 10e. Street and Nu | | | | | | 10f. Zip C | ode | _ | | T- | 10g. Ci | tizen of What | Count | | |
| the Ma a or 28 tiffed a | 2 | 15 Wood | land Di | rive | | | | | 21 | 1146 | | | | U | JSA | | |
| th with | runerai | 11. Marital Status 1 X Never Marri | ind 2 Mr | | 2. Was Dec | cedent Ever in U | | s Decedent es, specify | | | | cify Yes or No | D~ | | Race - American Indian, Black, White, etc. | | |
| ", or it | | 3 Widowed | | 1 | Yes Yes, Give Yea | 2 X No | 1 | Yes 2 | x No | specify: | | | | Specify: | White | | |
| ntural samin | <u>a</u> | 15. Decedent's E | | or | Dates: | | 16a. Decedent | 's Usual O | ccupatio | n (Give kir | | | 16b. | Kind of Busine | ess/In | dustry | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Important! If item 27 is marked other than "antural", or items 23a or 28a-f abovinguy or other traumatic event, the Medical Examiner must be notified at once. | Completed | Elementary/Sec | ondary (0-12) | | College (1 | 1-4 or 5+) | | st of worki house | _ | | | u) | | Janit | or | ial Supply | |
| S-00; | 탉 | 17. Father's Name | (First, Middle, | Last) | | | | | 18 | .Mother's | Name (i | irst, Middle, | Maider | n Surname) | | | |
| 121 d be fill ental H arked vent, 1 | | Edwin M | | | D.I.I. | | Lion Mailine | Addense | (0) | | | Mary Re | | iles City or Town, S | 24-4- | · · | |
| AD 2 2 shoul 27 is m 27 is m | 2 | 19a. Informant's Na Eduardo | | | | | | loodla | | | | | | ark, MI | | | |
| re, N. 1 and F. Health | Ì | 20a. Method of Dis | position Cremation | 3 🗆 | Demoval fr | | Place of Disposi crematory or oth | | of ceme | etery, | Feb. | Date | 20c. | . Location - Cit | y or T | own, State | |
| Pages Pages nent of ant: I | 1 | | Other Sp | | Removal II | oiii State | Metro C | | ory | | 201 | 2 | | Baltin | nor | e, MD | |
| Balt Permit. Depart Import injury | 1 | 21. Signature of F | eral Se ce | nsee | <. 0 | Coms | -) Ba | ame and A | % OC | Sons | , P. | A. Se | veri | na Park | F | uneral Home | |
| ² hysician | - | 23 Part I. Enter th | he diseale, or | co figural | lions that o | aused the death | n. Do not enter th | 5 Rit ne mode of | Ch16 dying, st | HWY uch as car | diac or r | espiratory an | veri rest, sh | na Park nock, or heart | • | MD 21146 Approximate Interval | |
| /Medical Examiner | 1 | Immediate gause | nly one caude (Final disease | | _{iine.} Iltiple Inj | uries | | | | | | | | | | Between Onset and Death | |
| | ı | or condition resulti | ing in death) | Due | e to (or as a | a consequence o | of): | | | | | | | | | | |
| | į | Sequentially list co if any, leading to in cause. Enter Under | mmediate | Due | to (or as a | a consequence o | of): | | | | | | | | | - | |
| be executed sician and urial - transit | | (Disease or injury to events resulting in | that initiated | c. Due | e to (or as a | a consequence o | of): | | | _ | | | | | - | | |
| O, s be executed rsician and burial - transit | <u>8</u> - | | | d | | | | _ | | | | | | | | | |
| e be ex | ~ - | UNPENDED |) | | MENDED | | | | | | | | 1 2 | 2d Data of do | ivon | | |
| 5876 rtificat ling ph | an/m | IF FEMALE: 23b. Was decedent past 12 months | | | 1 Live b | | 2 Fet | al death | 3 | Ectopic p | oregnand | су | 12. | 3d. Date of del Month | Da | ay Year | |
| Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transity of the physician for the physician | Pnysician/m | 1 Yes 2 | | nown 4 | 4 Pregnant at time of death 5 Other (Specify) | | | | | | | | | | | | |
| at the d | | Part II. Other sign | ificant conditi | ons co | ntributing t | o death but not i | resulting in the u | nderlying c | ause giv | en in Part | 1. | | | _ | | ne cause of death? | |
| cords, P.O. law requires that th has been signed by 2 should be detach | 90 09 | | | | | | <u></u> | | | | | | | | | ably 4 Unknown | |
| ords aw requas been as been 22 should | Сошріете | | | | | | | | | | | 24a. Was auto | | prio | r to co | opsy findings available ompletion of cause of | |
| Rec The la | | | | | | | | | | | | 1 ✓ Yes | | | Yes | 2 No | |
| Vital Rel hysician: The this certificate I director, page | 8 | 25. Was case refer examiner? | rred to medical | | pital: 1 | Innationt 2 | ER/Outpatient | | 10 | f Death (C | | lly one) Home 5 | Posid | dence 6 0 | Other: | | |
| ing Physineral di | | 1 Yes 27. Manner of Dea | 2 No | | 28a. Date | of Injury | 28b. Time of Ir | | | at Work? | 2 | 8d. Describe | how in | njury occurred | | | |
| ion tendin tor: A the fur | | 1 Natural 2 Accident | 5 Pend | ling stigation | Jan 28, | 2012 ear) | 0000 hrs | | 1 Ye | s 2 🗸 N | 40 D | river of au | ito in | volved in c | OlliSi | on | |
| Division of Vital Records, the Hospital or Attending Physician: The law requiring the 24 hours after death. The Tangan after death. The Tangan Director. After this certificate has been an oppetely filled in by the funeral director, page 2 should be a continued to the funeral director. | Certification: | 3 Suicide | 6 Coul | d not be | 1 | | nome, farm, stree | et, factory, o | office bui | lding, etc. | | or Town, | State) | | r Rur | al Route Number, City | |
| y fil | | 4 Homicide | | | | | d / Highway dge, death occur | red at the t | ime, date | and plac | | oute 50 / Re ue to the cau | | | state | d. | |
| To the Hos within 24 h To the Fun completely | Medical | one) 2 | | miner: Or | | of examination a | and/or investigat | | | | | | | | | | |
| | Ě | 29b. Signature and | title of certifie | r | 1/ | , | | | License | | | | | l. Date signed | | | |
| | | 30. Name and add | Ym | 1. | | ee of death /li- | n 23a) | | O.C.M | | | | Jai | nuary 29, 2 | .012 | | |
| 15 | | Jack Titus I | 7 | | 70 | se or death (iten cal Examine | | Baltimore | e Stree | t, Baltin | nore, I | MD 21223 | 3 | | | | |
| Stat Registra | ~~ | 31. Date filed (Mor | rth, Day, Year) | 2 20 | 12 32. R | egirtrar's Signat | ture A. | all | , | | | | | | | | |
| Kegistra | Ш | | ILUV | 4 50 | | Charles of | 10.0 | | | | | | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Month Francis Α. Dize Jan. 1914 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 25706 Frenchtown Road Westover Somerset Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 220-32-1245 1 M 2 D F 78 Oct. 7. Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Somerset Westover 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 25706 Frenchtown Road 21871 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates. 1956-58 white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Waterman Seafood

Fairmount Cemetery 01-28-2012

18. Mother's Name (First, Middle, Maiden Surname)

20c. Location - City or Town, State

Fairmount, Maryland

21853

Day

Year

Month

Approximate Interval Between Onset and Death

Alice French

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25706 Frenchtown Road, Westover, Md. 21871

22. Name and Address of Facility Hinman Funeral Home

must be notified 28a-f ö 23a death with "natural", or items dical Examiner mu Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I Department of H Important: If ite any injury or ot 1 - State Registrar

10a. State

Physician/

Medical

Examiner

Funeral Director

show

at

Director

Funeral

Completed by

Be

ပ

17. Father's Name (First, Middle, Last)

Anna Dize

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

Archie Dize

1 Burial 2 Cremation 3 Removal from State

Wife

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 30

Physician/ Medical Examiner

burial-trar signed by the attending physician d be detached for use as the burial After this certificate has been signe funeral director, page 2 should be filled in by the funeral director,

P.O. Box 68760

Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after deati Funeral Director. completely within 2 To the 0 Registrar

29b. Signat

MO0295 11673 Somerset Ave, Princess Anne, Md. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause diate Cause (Final Due to (or as a consequence of); ase or condition sulting in death) Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 L g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Other: ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Cath 28b. Time of 28c. Injury at work? Certificate: 28d Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

20b. Place of Disposition (Name of cemetery, crematory or other place,

29c. License number

114 SECOND STREET CRUMPTON Social Security Number 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min **Director** Yrs. 222-32-1711 95 04/18/1916 Usual Residence of Decedent 28a-f show i Hygiene. other than "natural", or items 23a or 28a-f shov ---◆ +h∞ Medical Examiner must be notified at 10b. County 10a. State Director 10c. City, Town or Location MARYLAND | QUEEN ANNE'S CRUMPTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 SECOND STREET 21628 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 2 XNo 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic.... 12 MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLARD C. BIDDLE LEONA WILLIAMSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR B. DAVIS / SON 8659 WEIR STREET MANASSAS, VIRGINIA 20110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 Tremation 3 ☐ Removal from State 4 Dopation 5 Other (Specify) CHESAPEAKE CREMATION 02/02/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ FAILURE TO THRIVE Medical Examiner CONGESTIVE HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ RENAL INSUFFICIENCY Records, Completed page 2 s Yes of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at injury 1 Natural 5 Pending Division s after death. Accident Investigation М 1 Yes 2 No 2 Accident 3 Suicide 4 Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

For State Registrar

Physician/

Medical

Examiner

Decedent's Name (First, Middle, Last)

KATHRYN MABEL BIDDLE DAVIS

4a. Facility Name (if not institution, give street and number)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City. Town, or Location of Death

2. Date of Death

JANUARY

3. Time of Death

2:30

10d. Inside City Limits 1 X Yes 2 No

Birthplace (State or Foreign Country)

MARYLAND

2012

QUEEN ANNE'S

4c. County of Death

UNITED STATES

16b. Kind of Business Industry

COSMETOLOGY

20c. Location - City or Town, State

Specify:

14. Race - American Indian, Black, White, etc.

WHITE

Approximate Interval Between
Onset and Death HEART FAILURE 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D0041587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) speer Rd. Chestertown, MD 21620

DHMH 17 Rev 7/2009

State

Registrar

Medical

29a. Certifier

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Noble

MO

122

32. Registrar's Signature

2355 28a-f show AND 181 2014 with the Maryland ō 5-0036 2121 Baltimore, Maryland DARB NAN Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2012 2355 PM Nancy Joan Darby 28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Months Davs Hours Min. 226-42-9673 **Director** 1 □ M 2 🛢 F March 25,1932 Virginia 79 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director notified 1 Yes 2 No Germantown Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be i Funeral IISA 20874 21000 Father Hurley Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian "natural", or iter idical Examiner Armed Forces? Black, White, etc. by 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced White Department of Health and Mental Hygiene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rettie Caylor Lawrence Good 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20409 Watkins Meadow Drive, Germantown, MD 20876 Warren D. Darby, Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Goshen Mennonite Feb. 2, 2012 Laytonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 21. Signature 26401 Ridge Road, Damascus, MD 20872 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipck, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner any, reading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of the attending physician a hed for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 🗌 No certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital: 1 🗌 Yes 1 Inpatient 2

Date of injury ER/Outpatient 3 DOA ုင 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) iniury work?
1 Yes 2 No 1 Natural 2 Accident 5 Pending nours after death.

neral Director: Aff
filled in by the fur Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi (Check only one 29b. Signature and t 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Division of Vital

cause of death (Item 23a) (Type, Print)

State Registrar ON

NARR 31. Date filed (Month, Day, Year) FEB 03 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

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MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 18 per Registrar 2/3/12 LDB

1. Decedent's Name (First, Middle, Last) Amend 18 per FD, DOR, Certificate of Death 2. Date of Death 3. Time of Death Physician/ 2012 8:16^{AM} James Cagney Fchard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3614 <u>Karen Circle</u> inkwood Dorchester 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Washington, DC (Month, Day, 1 👿 M 2 🗆 F Months 577-48-3799 Director Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Dorchester Linkwood 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21835 3614 Karen Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen-Caldwell Arlene Alexander ೭ John William Echard Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Payne/ daughter Centenary Drive Salisbury Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crownsville Veterans 2-6-2012 Crownsville, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 308 High St. 21613 Cambridge. Newcomb and Collins FH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Advanc Onset and Death Immediate Cause (Final Demecha Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate
cause Enter Underlying
Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 1 Ho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 Wo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 🗆 🕠 မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗆 Yes 2 🗆 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12

Registrar DHMH 17 Rev 7/2009

State

503 BYRN ST CAMPRIDGE MD 2613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANCUY

32 Registrar's Signatur

NOMAN

31. Date filed (Month, Day, Year)

FEB 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ Feb. Eshbaugh 5:20 A. M Frances Erma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 125 Central Avenue Brunswick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours Apr. Tay, ¶942 Mary and 218-40-3684 69 1 □ M 2 🛣 F Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director MD Frederick Brunswick 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 ms 23a or must be r Funeral 125 Central Avenue 21716 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status "natural", or ite Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White 3 Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Battery store 0wners Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Erma Frances Powers Francis Ulysses Carey t. Page 1 and 2 should be thrent of Health and Mentrant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Central Avenue, Brunswick, MD 21716 William E. Eshbaugh - Husband permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Brownsviile Heights 2-4-2012 Brownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eackles-Spencer Harpers Ferry, ¥ & WV Norton Funeral Home 25425 Roch 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or s a cons guence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or injury tran and that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialattending physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Year Pregnant at time of death Month Day 9 Unknown 9 Unknow þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed I should be det Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ known Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 1 ☐ Yes 2 No 1 X Yes 2 No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only ne) Be examiner? Hospital Other: 2 X No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funer ompletely filled in by the funer injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated # Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month. Day, Year) 29c. License number 02/01/2012 D68104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Traderick 6

State Registrar 31. Date filed (Month, Day,

Year)

strar's Signature

32. Rea

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 950AM 2012 JOAN FREEMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS ENTERVILLE LEEN HEALTHCARE 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ☐ M 2 🕱 F (Month, Day, Year) 01/07/1938 Months Days Country) 218-34-8673 74 Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD Kent Worton 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò event, the Medical Examiner must be Funeral 23a USA 25020 Lambs Meadow Road 21678 items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married 2X No 9 Yes hours after Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: If Yes, Give Black Specify: 3 X Widowed 4 ☐ Divorced "natural". Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Packer/Transporter Manufacturing marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gladys Charles McKindley Lively Frances Hynson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. 1 and 2 s of Health item 27 i Worton, MD 21678 Roderick Freeman P.O. Box 94 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of Mtemetery Framatory or other place) 20c. Location - City or Town, State Page 1 ó Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Worton, MD 2/11/12 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 22. Name and Address of Facility Bennie Smith Funeral Home 855 High Street Chestertown, MD 21620 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ OVARIAN METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician at the burial-Physician/Medical that the death certificate be Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death the detached 9 🔲 Unknown P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ pe Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law has autopsy performed certificate 2 🗌 No 1 Yes Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ၉ 1 🗌 Inpatient 2 🗎 ER/Outpatient 3 🗌 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) hin 24 hours after death. the Funeral Director: After this funeral 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) or Attending Watural $5 \square$ Pending 1 ☐ Yes 2 ☐ No М Investigation Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Decrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

29b. Signature and title of certifier

SHIRENE

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

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32. Redistrar's Signature

29c. License number

NE

ARMSTRONG

29d. Date signed (Month, Day, Year)

CENTERVILLE MO 21617

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #55 PeroFMasyland 3 begarine at JH Health and Mental Hygiene Bruce Edward Freeman 2012 04714 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day January 27, 2012 **Medical Examiner** 2100 hrs BRUCE EDWARD FREEMAN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6040 Hynson Road Rock Hall Kent If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Social Security Number 6. Sex 7. Age (In vrs. last birthday) Foreign 221-54-2738 Days Director 1 **X**M 2 F 221-57-2738 MARYLAND 12/25/1964 47 Usual Residence of Decedent III 10a, State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 X Yes 2 No 23a or 28a-f shov notified at once, ROCK HALL KENT Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6040 HYNSON ROAD UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: WHITE <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 AUTOMOTIVE AUTO MECHANIC 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) nt of Health and Mental Hit: If item 27 is marked other traumatic event, i Be SHIRLEY ANN NACE JAMES CUMBERLAND FREEMAN 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD SHIRLEY FREEMAN 6040 HYNSON ROAD ROCK HALL, MARYLAND 21661 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) 1 XBuria! 2 Cremation 3 Removal from State 02/04/2012 ROCK HALL, MARYLAND 4 Donation 5 Other Specify WESLEY CHAPEL CEM. permit. 21. Signature of Funeral Service Licensee

Buka Helpho 22. Name and Address of Fac FELLOWS, HELFENEBIN & NEWNAM FUNERAL 130 SPEER ROAD CHESTERTOWN, MARYLAND HOME, 21620 23a. Part I. Enter the disease, Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. een Onset and /Medical a. Intraoral Gunshot Wound Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit To the Hospital or Attending Physiciao: The law requires that the death certificate be executed within 24 hours after death.

To the Fuoeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Physician/Medical UNPENDED attending physician or use as the burial -AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No 25 Was case referred to medical 26.Place of Death (Check only one) of Vital B examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes 2 No 28a. Date of Injury FOUND: Day,Year) 27. Manner of Death 28b. Time of Injury 28c, Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self FOUND: Division Natural 5 Pending 1 Yes 2 ✔ No Jan 27, 2012 0000 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide 6 | Could not be or Town, State) 6040 Hynson Road, Rock Hall, MD determined (Specify) Woods Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and little of cert 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 28, 2012 de 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ERGUSON 2012 0959 Q M AVID UNDLEY TAN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** KENT CHESTER HESTERTOWA If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 227 40 3367 Months Hours Min. Country) Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director STREET CANNON MD KENT 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 21620 HESTERTOWN U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Force Black, White, etc ò δ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE "natural", Completed 3 ₩idowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) URIENTAL RUES 451NESS OWNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MADELINE PERGUSON LAUDE permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 241 HIGH STEEF KHODES CHESTERTOWN, MD ERGUS ON 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or offer place) 1 Burial 2 Cremation 3 Removal from State HESAPEAKE CREMATON CHESTER 4 Donation 5 Other (Specify) 22. Name and Address of Facility
MARYIN VIIII MAS, 72 FUNERAL DIRECTOR 21. Signature of Funeral Service Licenses 400625 DIRECTER. 21622 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ railure to THRIVE disease or condition Medical resulting in death) Examiner with Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed Is chemit CADIOMY of atty 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 📳 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred 5 Pending
__Investigation 1 Ratural Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

Rm

Box 68760

P.O.

An-H.D. 2231/16 Street

and address of person who completed cause of death (Item 23a) (Type, Print)

ARRABAL

1)2388

| 2-01146 | | Please Type or Print in Black Indelible Ink. Ensure All Copies | Are Leg | ible. | |
|--|-------------------|---|------------------------|-------------------------------|---|
| onald Anthony | | 1- For State Certificate of Death | | 201 | 2 0471 |
| Physicia | _ | Registrar 1. Decedent's Name (First, Middle,Last) 2. I | Date of Death | | 3. Time of Death |
| ***dical Exami | | Donald Anthony Fanucci F | ebruary 8 | , 2012 | 0748 hrs |
| | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 41 Vista Drive Elkton | | 4c. County of Death Cecil | |
| Funeral | | | . Date of Birth | h(MM/DD/YYYY) 9. Bir | thplace (State or |
| Director | | 220-86-9498 1XM 2 F 48 Yrs. Months Days Hours Min. | Nov. | 1,1963 Co | ountry) PA |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| | _ | MD Cecil Elkton | | | 1 Yes 2 No |
| Maryland 28a-f show d at once. | Director | 10e. Street and Number 10f. Zip Code | 10 | g. Citizen of What Cou | intry? |
| ith the Maryland 23a or 28a-f sho notified at once. | | 41 Vista Dr. 21921 | | USA | to die Blad |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once | Funeral | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No | | White, etc. | ican Indian, Black, |
| fter de | | 3 Widowed 4 Divorced If Yes, Yes 24 No 1 Yes 24 No 1 Yes 27 No specify: | | Specify: Wh | ite |
| nours a | ed by | 45 Decedent's Education (Specific only highest grade completed) 169 Decedent's Usual Occupation (Give kind of work | | 16b. Kind of Business/ | 'industry |
| 136 ihin 72 hours : te. than "naturi edical Exami | plet | Elementary/Secondary (0-12) College (1-4 or 5+) Carpentry Foreman | | Constru | ction |
| MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the <u>Medica</u> | Completed | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) | rst, Middle, M | | |
| 215 be file antal H arked | Be | Donald F. Fanucci Mary Ar | nn Sta | ankosky | 7'- 0-1-) |
| D 2's should and Me | To | 19a. Informant's Name/Relationship (Type, Print) Jane E. Fanucci/ wife 19b. Mailing Address (Street and Number or Rural 41 Vista Dr. Elkto | | | e, Zip Code) |
| Ore, MD 2121 se 1 and 2 should be fi of Health and Mental I If item 27 is marked her traumatic event, | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, D | ate | 20c. Location - City or | Town, State |
| ADDE ages 1 nt of F. nt: If i | | 1 N Burial 2 Cremation 3 Removal from State West Nottingham Cem 2/14 Donation 5 Other Specify: West Nottingham Cem 2/14 | 4/12 | Colora, | MD |
| Baltimore, Dermit. Pages 1 and Department of Heal Important: If item | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral | | <u>·</u> | |
| Physician /Medical | 2 | 23a. Plart I. Enter the disease, or complice ons that caused the death. Do not enter the mode of lying, uch as cardiac or refailure. List only one cause on each ne. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | spira ory arre | ing Sun est, sock, or eart | Approximate Interva Between Onset and Death |
| | Jer | Sequentially list conditions, | | | |
| sit de Carl | Examine | cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). | | | |
| | _ | | | | |
|), be exe sician a | dic | □ AMENDED 23a,27,28a-f,per me,g924 2-22-12 | . sm | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trar | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (Specify) 9 Unknown | | | Day Year |
| hat the ed by t | by Pi | | | bacco use contribute to | |
| Sy Pauries t quires t en sign | | | 24a. Was a | an 24b. Were a | utopsy findings availabl |
| COTC law re has be | Completed | | | med? death? | completion of cause of |
| Re ifficate r, page | | | 1 Yes | 2 No 1 Y | es 2 No |
| /ital /sician nis cert directo | o Be | examiner? Hospital: A leastingt 2 FD(Outputiont 3 DOA Other, Nursing b | | Residence 6 🗸 Othe | er: Scene |
| of or ng Phy | 입 | | | now injury occurred | 1 |
| Sion ttendi death. ctor: 4 | Certification: | Natural 5 Pending Investigation Accident Fd 2-8-12 Fd 7:30 am 1 Yes 2 X No S O 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. | verdos | accidenta | tural Route Number, City |
| Divis al or A s after al Dire | tate)41 V1SCa | Dr. | | | |
| Division of Vital Records, P.O. B To the Hospiral or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached | | | Ikton. le to the caus | se(s) and manner as sta | ated. |
| To the within To the comple | Medical | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at transport and the of cartifier 29b. Signature and the of cartifier 29b. Signature and the of cartifier 29c. License number | in time, date | 29d. Date signed (M | |
| | | O.C.M.E. | | February 9, 201 | |
| _ | | 30. Name and address of person who completed cause of death (Item 23a) | | | |

State 31. Data filed (Month, Day Year) Registrar

Victor Weedn MD JD

32. Registrar's Signature

DOME

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Peter Guilday 2012 January 30, 4:30pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Centreville Hospice of Queen Anne's Queen Anne's 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Hours Country) 577-32-8617 Director 1 X M 2 □ F 83 PA April 6, 1928 Usual Residence of Deceden 28a-f shov at 0a. State 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified MD Queen Anne's Chester 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 30F Queen Mary Court 21619 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 nan "natural", 1 ☐ Yes 2 X No Specify: White Year or Dates. Korea Completed 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Graphic Illustrator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael Delaney Guilday Esther Lawler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Guilday/Wife 30F Queen Mary Court Chester, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State cemetery, crematory or other place, Feb. 2012 Metro Crematory 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line ostate Cancer Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year the be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 \square Pending 1 Tyes ☐ Accident Investigation Suicide 6 Could not be completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature a 29d. Date signed (Month, Day, Year) 06527 1131112 on who completed cause of death (Item 23a) (Type, Print) Name and address of pers

State Registrar 31. Date filed (Month, Day, Year)

MIDIUI

2003

Plumy Sute 200 Ann. p.113 MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gilchrist Physician/ E11a Bernadette January 24, 2012 11:53 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 🗓 🗓 F 171-18-3064 93 0571471918 Pennsylvania **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Camp Springs Marvland 1 Yes 2 KNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6007 Wesson Drive 20746 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify: 3XX Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Court Stenographer years Court System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bela Winter Anna Buchina if, Page 1 and 2 shouse of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meoli - Executor 5910 Great Star Drive #206 Clarksville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Md. Veterans Cem. 02/13/2012 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature neral Service Licen 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No 9 Unknown 9 Unknown Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 x xNo 25. Was case referred to medical examiner? **Division of Vital** Be funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death.

Director: Aft
d in by the fur 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 00060100 01-25-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TA ftm in 16 A ifm PD 14 MO 31. Date filed (Month, Day, Year) JAN 27 2012

DHMH 17 Rev 7/2009

Registrar

Box 68760

| | | | State of Maryland / Department | | Mental Hygiene | 2 |
|----------|---|------------------|--|--|---|----------|
| | | | riogional | tificate of Death | Reg. No. 2012 UH11 | _ |
| | Physicia | n/ | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year 3. Time of Death | - |
| | Medic | | Christine V. Hollon | T | 02 02 2012 5:15 P M | 4 |
| | Examin | er | 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | · · | |
| * | | | 53 Bonney Shores Road 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) | E1kton If Under 1 Year If Under 24 Hrs. | Cecil 8. Date of Birth 9. Birthplace (State or Foreign | \dashv |
| | Funeral Director | | 579-14-2073 1 □ M 2 □ XF 90° FS. | Months Days Hours Min. | (Month, Day, Year) S/30/1921 OK | 1 |
| | | | Usual Residence of Decedent | | 1 3/30/1921 L OK | ゴ |
| | shor shor dat | 호 | 10a. State 10b. County 10c. City, Town or Lo | cation | 10d. Inside City Limits | |
| | Mary 28a-f otifie | <u> e</u> | MD Cecil Elkton | | 1 ☐ Yes 2 🛣 No | ╝ |
| | a or be n | | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? | |
| 3 | n with | Funeral Director | 53 Bonney Shores Road | 21921 | USA | 4 |
| | deat riten ineri | | Armed Forces? | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No- p Rican, etc.) 14. Race - American Indian, Black, White, etc. | - |
| 5 | after al", o xam | d by | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 No Widowed 4 Divorced Year or Dates. | 1 ☐ Yes 2 🛣 No Specify: | Specify: White | - |
| 50 | atura ical E | Completed | 15. Decedent's Education 16a. Decedent | dent's Usual Occupation | 16b. Kind of Business Industry | \dashv |
| -617 | an "n Medi | E G | (Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+) | kind of work done during most of work O NOT use retired) | king | - 1 |
| 7 | within giene er th , the | | Teac | her | Special Education | Ц |
| | ⊞ed Hy did Hy did Hy did Hy did Hy svent |) Be | 17. Father's Name (First, Middle, Last) | 18. Mother's Nam | ne (First, Middle, Maiden Surname) | |
| <u> </u> | ld be Ment arke | မ | Forrest L. Binswanger | Clara C | Combs | 4 |
| <u>.</u> | shou and is m raum | - 24 | | ng Address (Street and Number or Rur | ral Route Number, City or Town, State, Zip Code) | |
| ร์ บั | and 2 lealth am 2 ther t | | | | 1, Elkton, MD 21921 | 4 |
| 5 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cref | natory or other place) | Date 20c. Location - City or Town, State | |
| Daltimor | it. Pa rtmei rtant njury | | | | 72012 Rising Sun, MD R.T.Foard Funeral Home PA | - |
| ם | permi Depar Impol any ir | - 90 | | | E, Elkton, MD 21921 | Į |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent | | | |
| ь | hesician/ | | shock, or heart failure. List only one cause on each line. Immediate Cause (Final | | Interval Between Onset and Death | |
| | Medical | 18 | disease or condition resulting in death) a. Due to (or as a consequence of): | ascundid | | - |
| - | Examiner | | | | | |
| | | iner | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | ٦ |
| | oured nd transi | xam | Cause (Disease or linjury that initiated events c. | | | 4 |
| | e exe | dical Examiner | resulting in death) Last Due to (or as a consequence of): | | | |
| 3 | are p physic the b | g | d | | | Ⅎ |
| 00 | ding | Physician/Me | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | | 23d. Date of delivery | |
| Š | atten for us | ciar | in the past 12 menths? | Ctopic pregnancy Other (specify) | Month Day Year | |
| 0 | y the | hysi | 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown | | | _ |
|) | rnar r ned b deta | by P | Part II. Other significant conditions contributing to death but not resulting in the u | underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? | - |
| 'n. | n sign | 8 | | | 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown | |
| 5 | s bee | plet | | | 24a. Was an autopsy findings available prior to completion of cause of | ٦ |
| necorus, | ne ian te ha: age 2 | Completed | | | autopsy prior to completion of cause of death? 1 □ Yes 2 🏿 No 1 □ Yes 2 □ No | 1 |
| 0 | an; I rtifica tor, p | Be C | 25. Was case referred to medical | 26. Place of Death (Chec | | ╛ |
| VICAL | nysica nis ce direc | 인 | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien | nt 3 DOA Other: 4 Nursing H | lome 5 X Residence 6 ☐ Other (Specify) | ╝ |
| 5 | ng Pl | te: | 27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time or injury | f 28c. Injury at work? | 28d. Describe how injury occurred | |
| 5 | leath. or: A the fu | ifice | 2 Accident Investigation | M 1 Yes 2 No | | _ |
| VISION | or At Ifter d Sirect in by | Certificate: | 4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify) | eet, factory, office | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 5 | ours a eral D | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death | occured at the time, data and place, a | and due to the equee(s) and mapper as stated | \dashv |
| | 24 hg 24 hg Fun leted | Medical | (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, | tigation, in my opinion, death occurred a | at the time, date and place, and due to the cause(s) and manner state | d. |
| | To the chospital or Attending Priysician; The law requires that the clearly certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | 2 | 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) | 7 |
| | | | 1 - 1(11ab - | D005408 | 310 2/10/12 | |
| | 2 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, I | | I III w. Han St Sute 10 | 3 |
| | | | | Jamu Kha | TRIM EIKton, MD 21911 | Ц |
| | Stat Registra | | 31. Date filed (Month, Day, Year) FEB 0 6 2012 June 9. Segistrar's Signature | | | |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First_Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 12:05 \mathbf{P}^{M} January Helen Irene Hiser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Mount Airy 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day, Year) 203-12-8119 3284 89 Director 1 🗆 M 2 🎛 F Yrs December 30, 1922 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 🗌 Yes 2 🔀 No 10e. Street and Numbe o 10f. Zip Code 10g. Citizen of What Country? must be Funeral 5690 Farmhouse Drive 21703 United States of America items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Examiner Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify White Specify "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Det artment of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic on e. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Operator Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Ethel Keys Albert Henry Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5690 Farmhouse Drive, Frederick, Maryland 21703 Linda Jane Smyth / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State metery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State January 31, Smithsburg Crematory Smithsburg, Maryland 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral S 22. Name and Address of Facility **Keeney & Basford P.A. Funeral Home** M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 1001 Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: Jse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnan 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month ģ Month Day Year Pregnant at time of death 2 🗷 Unknown 9 Unknown signed by the Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown been sig should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has director, page 2 perform death? 2 🗌 No Yes Yes 25. Was case referred to 26. Place of Death (Check only one) Be 1103 examiner' Hospital 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral c 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred (Month, Day, Year) iniury work?
1 Yes 2 No 5 Pending ile noce in 24 hours after deam. the Funeral Director: Aft Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and time of certifier 29c License number 29d Date signed (Month Day Year) D16428 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 6 Casper E. Cline, MD 300 West Ninth Street, Frederick, MD 21701 Date filed (Month, Day, Year) 32. istrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 35 Francis Shirley Hossbach Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chesapeake Woods Center Cambridge Dorchester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Mary Land 1 😾 M 2 🗆 F Dec. 215-12-9893 91 1920 Director Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City. Town or Location 10d Inside City Limits Director MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6105 Twin Point Cove Road 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black White etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates ŬWΙΙ white Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the supervisor telephone company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ൧ Francis Shirley Hossbach Elizabeth MacDonald permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic of 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Brannock 3204 Ocean Gateway, Cambridge, MD daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

5t. John's Churchyard 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 2/4/12 Cambridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. e of Funeral Sc 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Mecosclecotic Immediate Cause (Final Onset and Death Physician. disease or condition Medical Examiner resulting in death) ue to (or as a consequence of) 24 (S Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and I-transit Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death
Unknown 1 Yes 2 9 Unknown Yes 2 No סמנש וומצ been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Pobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 X Yo ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 5 Pending 1 Patural thin 24 hours after death.

the Funeral Director: After missing the function of the function o 1 Tyes 2 🗌 No Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date

Saltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

 $\mathcal{D}_{r}0$

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e per FH G925 3/22/2012 JH State of Maryland / Department of Health and Mental Hygiene 2 0 2 For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 М 1:10P Althea Louise Jackson January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min 578-22-9125 Director 1 🗆 M 2 🗶 F 96 May 16, 1915 Washington, DC Usual Residence of Decedent 28a-f shov at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director Examiner must be notified Maryland Anne Arundel Annapolis 1 Yes 2 X No 9 10e. Street and Number 1633 Elkwood Court 10f. Zip Code 10g. Citizen of What Country? 23a 1633 Sloping Woods Court 21409 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. "natural", or 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced Specify: White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မှ Berkley Haas Noreen Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert B. Edwards/Son 2517 Painter Court, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🌠 Burial 2 🗆 Cremation 3 🗀 Removal from State 20c. Location - City or Town, State Lincoln Cemetery 1/30/2012 Donation 5 Other (Specify) Brentwood, Maryland ral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 21. Signatur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardio Ph. sician/ disease or condition resulting in death) Medical r as a consequence of **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ρ Dav Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available 24a. Was an autopsy
performed

Yes 2 No prior to completion of cause of 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred atural injury work? 1 Yes 2 No 5 Pending s after death. Accident
Suicide Investigation 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State within 24 hours

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar

DATA WOOD

31. Date filed (Mont

Anne Avua

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONW

2012

MO

gistrar's Signature

29c. License number

000058291

29d. Date signed (Month, Day, Year,

| | | | State of Mary | | | | lental Hygie | ene | 01702 |
|--------------------------------|---|--------------|---|--------------------------|--|------------------------|---|---------------------------|--|
| | | | State Registrar | Cen | tificate of Dea | ath | | g. No.2012 | 04160 |
| | Physicia | n/ | 1. Decedent's Name (First, Middle, Last) | | | | Date of Death Month | _Dav _ Year | 3. Time of Death |
| | Medic | al | ELEANOR ELIZAI | 3ETH | JENKINS | | Heb. | 7° 2012 | |
| | Examin | er | 4a. Facility Name (If not Institution, give street and number) | | 4b. City, Town, or Loc | | | 4c. County of Deat | |
| | Formul | | Hart Heritage Estate 5. Social Security Number 6. Sex 7. Age (In | yrs. last birthday) | | reet Under 24 Hrs. | 8. Date of Birth | | ford hplace (State or Foreign |
| | Funeral Director | | | 90 Yrs. | | lours Min. | (Month, Day, Y | 921 Co | intry) Marvland |
| | | | Usual Residence of Decedent | <u> </u> | <u> </u> | | 10/10/1 | | |
| | yland f sho ed at | ţċ | | c. City, Town or Loc | | | | | 10d. Inside City Limits |
| | Mar 28a- notifie | Director | MD. Harford | | | tsvill | | | 1 ☐ Yes 2 🛣 No |
| | ith the 3a or t be i | ral | 10e. Street and Number | | 10f. Zip Code | 104 | 10 | g. Citizen of What Co | |
| | ath w | Funeral | 1214 Baldwin Mill Road 11. Marital Status 12. Was Decedent Ever | in U.S. 13. V | 210 Vas Decedent of Hispa | | cify Yes or No- | United 14. Race - Amer | |
| ထ | er dez or ite niner | by F | Armed Forces? | If | Yes, specify Cuban, N | Mexican, Puerto I | Rican, etc.) | Black, White | |
| ğ | rs aft Iral", Exal | edk | 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒️ No Iff Yes, Give Year or Dates. | 1 | ☐ Yes 2 X No S | Specify: | | Specify: | hite |
| 5-0 | 2 hou "natu adical | Completed | 15. Decedent's Education (Specify only highest grade completed) | 16a. Deced | lent's Usual Occupation | n ng most of workii | ng 1 | 6b. Kind of Business | |
| 121 | thin 7 sne. than | ĕ | Elementary/Seconday (0-12) College (1-4 or 5+) | life. DC | O NOT use retired) | + | | Departm | Navy |
| D | ed wii | Be | 11 4 | | Accoun | | (First, Middle, Ma | | Navy |
| an | be file ental ked c | 힏 | Ralph Jenl | rins | 1.0 | Cor | • | | Clwain |
| ary | nould nd M s mar | | 19a. Informant's Name/Relationship (Type, Print) | | g Address (Street and | | | | Code) 21084 |
| Ž | d2sh altha n27i ertra | | Betty J. Fuller (Sister | r) 1216 | Baldwin | Mill | Rd. J | arrettsv | rille, MD. |
| Baltimore, Maryland 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State | 20b. Place of Dispos | sition (Name of natory or other place) | Feb | Date 11, 2 | 0c. Location - City or | Town, State |
| Ĕ | Page ment ant: I | | | | Cemetery | | | lew Park, | Penna. |
| 3alt | permit. Depart Import any inj | | 21. Signature of Funeral Service Licensee | 22. | . Name and Address or | | | z & Son | |
| ш | = w o | Н | 11. Starteten Turk | | Home, P.A | | | ille, Ma | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. | | | uch as cardiac o | r respiratory arrest | , | Approximate Interval Between Onset and Death |
| | Physician/ Medical | | resulting in death) | ensl Pr | oilun | | | | YEARS |
| | Examiner | | Due to (or as a co | nsequence of): | | | | | |
| | | ner | Sequentially list conditions, b. Due to (or as a co | nsequence of): | | | | | |
| 83 | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or iinjury | | | | | | |
| 38 | exect an an rial-tra | EX | that initiated events c. Due to (or as a co | nsequence of): | | | | | |
| 09 | ate be executed by sician and the burial-transit | dical | d | | | | | | |
| 387 | rtifica ing pl | /Me | IF FEMALE: | | | | | | - |
| Box 687 | ath certifica attending p | ian/ | 23b. Was decedent pregnant in the past 12 morths? 23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim | Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of del Month | lvery Day Year |
| ă | e dea the a | Physician/Me | 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at tim g ☐ Unknown 9 ☐ Unknown | e or death 5 L | Other (specify) | | | | |
| P.0. | requires that the de been signed by the should be detached | y Ph | Part II. Other significant conditions contributing to death but n | | | | 23e. Did toba | cco use contribute to | the cause of death? |
| s, | uires t n sign ild be | q pe | Congestive Heart En | lure, | DEME- | 41 | 1 🗆 Yes | 2 🗆 No 3 🗆 P | robably 4 Unknown |
| oro | w requ | plet | | | | | 24a. Was an | | topsy findings available completion of cause of |
| 3ec | he lav ite hav | Completed by | | | | | autopsy perform 1 \(\sum \) Yes 2 | ed? death? | 2 No |
| a | ian: 1 ertifica ctor, p | Be C | 25. Was case referred to medical examiner? | | 26. Place | of Death (Check | | / | esisted |
| ₹ | hysic his ce | ပ္ | | 2 ER/Outpatien | | | me 5 🗌 Residen | ce 6 Other (Spec | ity) CANE |
| ٥ | ling F | Certificate: | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Ye | ear) 28b. Time of injury | 28c. Injury at work? | ; 2 □ No | 28d. Describe how | injury occurred | |
| Sior | death ctor: / | tific | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - | At home, farm, stre | | | 28f Location /Stre | et and Number or Ru | al Route Number |
| Division of Vital Records, | after Direction by | | 4 Homicide determined building, etc. (S) | | oct, ractory, crisc | | City or Town, | | ar / route / variable, |
| | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical | 29a. Certifier 1 Certifying Physician: To the best of my | | | | | | |
| | the He In 24 the Ft | Мес | (Check 2 ☐ Medical Examiner: On the basis of exam only one) 3 ☐ Certifying Nurse Practioner: To the best | | | | | | |
| | To t | | 29b. Signature and title of certifier | | 29c. License nu | | | d. Date signed (Month | |
| | 1 | | (M/1/L-M/) | | LP . | 2188 | () | abruary | 1, 2012 |
| | 0 | | 30. Name and address of person who completed cause of death OL COAD SPANIS | (Item 23a) (Type, P | W. Mpipi | HAIL | Bel Air | MD 21 | 014 |
| | Stat | <u>.</u> | 31. Date filed (Month, Day, Year) 32. Registrar's 3 | | , , , . | | , , , , , | . 07 | - / |
| | Registra | | FEB 1 7 2012 Several S. | parker | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | For | | State of M | laryland / | | | | | nd Me | ental Hy | giene | | | 0.1 | 701 |
|---------------------|--|------------------|--|-----------------------------------|--|----------------------------------|-------------------------|----------------------------|--------------------------------|----------------------------|------------------------|--------------------------------|--------------------|-------------------------------------|--------------------|---|---------------|
| | | | State Registrar | | - | | Cer | tificate | of D | eath | | | Reg. No. | 201 | 2 | 04 | 124 |
| | Physicia | ın/ | Decedent's Name | , , | | | | | | | | 2. Date of Dea _Month | Day | | ar | 3. Time of | |
| والمعاد | Medic | al | 4a. Facility Name (if r | | race Koo | ntz | | | | | | anuan | 71 | | | 02:10 | M |
| - To | Examin | er | The John | is Hople | ins Hospi | Fal | | Back | timo | ocation of | Cita | 1 | 40. | County of I | Jeath | | |
| | Funeral | | 5. Social Security Nu | | 1 | ge (In yrs. last bi 0 | | If Under Months | Days 20 | If Under 24 Hours | 4 Hrs. Min. | 3. Date of Birt (Month, Dat | | g | Birthpla Countr | ace (State o | or Foreign |
| | Director | | Usual Residence of | | □ M 2 X F | U | Yrs. | U | 20 | | J | an. 6, | 201 | 2 | Mary | land | |
| | shov d at | 호 | 10a. State | 10b. County | | 10c. City, Tov | wn or Loc | cation | | | | | | | 10 | d, Inside Ci | ity Limits |
| | Mary 28a-f otifie | irec | MD | Frederi | ck | Fr | eder: | ick | | | | | | | | 1 X Yes | 2 🗆 No |
| | is filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Funeral Director | 10e. Street and Num 1502 Nor | | t Street | | | 10f. Zip | 2170 | 1. | | | | izen of Wha $\cdot S \cdot A \cdot$ | t Count | y? | |
| | death v items ner mu | | 11. Marital Status | | 12. Was Decedent Armed Force | Ever in U.S. | 13. W | Vas Deced Yes, spec | ent of Hispify Cuban, | panic Origii , Mexican, | n? (Speci Puerto Ri | fy Yes or No- can, etc.) | | 14. Race - / | | | |
| 036 | s after ral", or Examii | ed by | 1 X Never Marrie 3 Widowed 4 | | Armed Forcey 1 Yes 2 If Yes, Give Year or Dates. |] No | | ☐ Yes | | | | | | Cnocify: | Whit | | |
| Š Č | hour hatur dical | olete | (Snec | 15. Decedent's E | ducation | 16 | | lent's Usua | | tion ing most o | of working | | 16b. Ki | ind of Busin | | | |
| 121 | thin 72 ne. than ' | Completed | Elementary/Secon | | College (1-4 or | 5+) | life. DO | O NOT use | retired) | ining most c | DI WOIKING | <i>'</i> | | Non | 0 | | |
| N D | ed with Hygien other the | Be C | 17. Father's Name (Fa | irst. Middle. Last) | | | | None | | 18 Mother | 's Name (| First, Middle, | Maiden 9 | | e | | |
| <u>Jan</u> | | 일 | | m Koontz | IV | | | | - 1 | | | nn Dur | | Surriamoy | | | |
| Maryland 21215-0036 | d 2 should be file alth and Mental H 127 is marked o er traumatic eve | 8 | 19a. Informant's Nar William K | | | 15 | 9b. Mailin 1502 | g Address Nort | (Street and h Ma | nd Number rket | or Rural F Stre | Route Number et, Fr | r, City or eder | Town, State | MD Co | 21.701 | l. |
| Baltimore, | Page 1 and 2 nent of Healtl ant: If item 2' ury or other t | | 20a. Method of Dispo | Cremation 3 | Removal from State | 20b. Place cemet | of Dispos tery, crem | sition (Nan natory or c | ne of ther place) |) | Da | te | 20c. Lo | ocation - Cit | y or Tov | n, State | |
| Ħ | permit. Page Department Important: I any injury or once. | - 8 | 4 Donation 21. Signature of Fundamental F | 5 Other (Specifier Service Licens | 1 | Resth | 22 | . Name an | d Address | of Facility | | /2012 | | | | ni este a | |
| Pa | permit. Departr Import any inji | | Red | TEX | det | | R | obert 201 i | E. Worth | Daile Mark | y & s | Son Fu treet, | nera Fre | 1 Hom deric | es, k, N | Р·А. Ф. 21 | 1.701 |
| | | | 23a. Part 1. Enter th shock, or heart Immediate Cause (F | failure. List only o | plications that cause ne cause on each lir | ed the death. Do ne. | not ente | r the mod | e of dying, | , such as ca | ardiac or i | respiratory arr | rest, | | | Approximat Interval Bet Onset and I | ween |
| | Medical | | disease or condition resulting in death) | | a. Due to (or as | a consequence | e of): | | | | | | | | + | 311001 4110 1 | - |
| من | Examiner | <u>.</u> | Sequentially list con | ditions, | b. Nec | rotisi | m | tni | Eroc | oliti | is | | | | | | |
| | ted Insit | Examiner | Sequentially list con cause. Enter Underl Cause (Disease or in | ying njury | Pres | nataril | 44 | | | | | | | | 204 | | |
| | be execu sician and burial-tra | | that initiated events resulting in death) Li | | Due to (or as | a consequence | e of): | | | | | | | | | | |
| 760 | icate l phys is the | ledical | | | d | | | | | | | | | | +- | | |
| Box 68 | requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit | Physician/M | IF FEMALE: 23b. Was decedent p in the past 12 m 1 Pyes 2 | onths? | | 2 Fetal dea at time of death | | Ectopic p Other (sp | | | | | . Ner | 23d. Date o Month | | | Year |
| J. O. | law requires that the nas been signed by the e 2 should be detach | | g Unknown Part II. Other signific | cant conditions c | | | g in the ur | nderlying (| ause give | n in Part I. | | 23e. Did to | bacco u | se contribu | te to the | cause of d | leath? |
| ds, | quires the | ted by | | | | | | | | | | 1 🗆 | Yes 2 | No 3 [| Proba | ably 4 🗆 | Unknown |
| Vital Records, | sician: The law red certificate has be director, page 2 sho | Completed | | | | | | | | | | 24a. Was autor perfo | nsy rmed? | prio dea | r to com | sy findings and pletion of co | |
| <u> </u> | cian: ertifica ector, | Be | 25. Was case referred examiner? | | Heeritek . / | | | | | ce of Death | (Check o | | | | | | |
| > | Physic this co | 은 | 1 Yes 2 | Mo | | tient 2 ER/C | | | | 4 ∐ Nurs | | e 5 🗆 Resid | | | (pecify | | |
| o uo | nding F tth. ; After e funer | cate | 27. Manner of Death 1 Natural 2 Accident | 5 Pending Investigation | 28a. Date of inj (Month, Da | | . Time of injury | M 2 | 8c. Injury a work? 1 🔲 Y | | | d. Describe h | ow injury | occurred / | | | |
| Division of | il or Atter after dea Director d in by th | Certificate: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not b determined | e 28e. Place of In | jury - At home, tc. (Specify) | farm, stre | et, factory | , office | | 28 | 3f. Location (S City or Tow | | | r Rural F | Route Numb | oer, |
| | To the Hospital or Attending Physician: "In thin 24 hours after death as the Funeral Director. After this certifical completely filled in by the funeral director, | Medical | (Check 2 | Medical Exami | sician: To the best of iner: On the basis of se Practitioner: To t | examination and | l/or investi | igation, in | my opinion | , death occ | curred at th | e time, date a | nd place, | and due to | the caus | se(s) and ma | anner stated. |
| | To the within the company of the com | | 29b. Signature and ti | tle of certifier | | | | | . License r | | 135 | , | | e signed (M | | | , |
| | , | | 30. Name and addres | ss of person who | completed cause of | death (Item 23a) |) (Type, P | rint) | 10 | 11 | ,,,, | Bal | gane | ury e | -0/ | 2/2 | 267 |
| | | | Christ | tonh | | m quy | 60 | ONO | reth | 20016 | est | Bak | timo | W. C. 1. | Mari | ghan | ed |
| ı | Sta Registra | | 31. Date filed (Month | EB () 1 2 | 040 3 | rar's Signature | 6 | arke | / | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 400M Medical 4a. Façility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 0-1 Hag erstown Washington Hagerstown 5. Social Security Number 650 If Under 1 Year If Under 24 Hrs. oate of (Month, . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛚 F Days Min. Waynesboro, **Director** 162-46-4331 60 Usual Residence of Decedent 28a-f shov 10a. State ms 23a or 28a-f sho must be notified at the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💆 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral [14014 Marsh Pike 21740 US "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Widowed 4X Divorced Specify. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lynn Ellsworth Kesselring Betty Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Stafford 11526 Monn Dr. Greencastle, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 02/14/2012 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Valley Crem. Waynesboro, PA Signature of Funer & Service Licens 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S. Broad St. Waynesboro, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Retween Immediate Cause (Final Onset and Death Phylician disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, it any, leading to immediate Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 1 Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown this certificate has been siral director, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☑ No 1 Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital 2 X No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suiciae 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) sonomi Same and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

oncoschaCRNP 31. Date filed (Month, Day, Year) FEB 1 7 2012

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14014

Marsh Pilce

MD21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9-2012 WILLIAM THOMAS LAWRENCE 1:16 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice at burn Nicomico Lake Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under Birthplace (State or Foreign Country) Hours Min. **Director** 220-68-9660 1 XM 2 □ F 53 Usual Residence of Decedent 07/09/1958 Maryland 28a-f shov ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗆 No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 245 N. Somerset Avenue 21817 U.S.A. items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner. 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates a Wrence Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Liquor Dispensary Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Donald Lee Lawrence Sylvia Fay Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Fay Lawrence (Mother Baltimore, <u> 245 N. Somerset Avenue - Crisfield, MD 21817</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sunnyridge Mem. Park | 02/01/2012 Crisfield, MD 21. Signature of Inc. 1 Samuel Inc. 1 See 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, Robert H. Bradshaw, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to minerial cause. Enter Underlying Cause (Disease or injury Que to for as a consecuer oe of: Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialnding physician use as the burial Physician/Medical P.O. Box 68760 use as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Pregnant at time of death Unknown g 🗌 Unknown ed by the been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No ြို 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manne Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director, A 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined filled in t Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number ause of death (Item 23a) (Type, Print) 10 910 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| | 2 | 0 | | 2 | 0 | 4 | 7 | 2 | - |
|--|---|---|--|---|---|---|---|---|---|
|--|---|---|--|---|---|---|---|---|---|

| | | 1- For State Registrar | | C | ertificate | of . | Death | | | | | Reg. No. | | / 1 6 | |
|--|----------------|--|--------------------------------------|------------------------------------|--|--------------|---------------------------------------|--|--------------------------|-------------------|---------------------------------------|----------------------|--------------------|----------------|---|
| Physicia ⊶dical Examir | ın/ | 1. Decedent's Name (First, Midd | le,Last) Renee | McReyn | olds | | | | | 2 | Date of De Month February | Day | Yea 12 | r | 3. Time of Death 0205 hrs |
| | | 4a. Facility Name (if not institution St. Mary's Hospital | on, give street and | number) | | 41 | b. City, To Leonar | | | f Death | | | County of | | |
| Funeral Director | | 5. Social Security Number 564-25-1816 | 6. Sex | | i. last birthday | Yrs. | If Under Months | 1 Year Days | If Under Hours | Min. | 8. Date of B | , | | Foreig | hplace (State or ⁿ California untry) |
| | ŀ | Usual Residence of Decedent | | | | | <u> </u> | <u>. </u> | 1 | | · · · · · · · · · · · · · · · · · · · | | | | |
| ow any | | 10a. State 10b. County Maryland St. | Mary's | 10c. Ci | ty, Town or Lo | | | | | | | | | | 10d. Inside City Limits 1 Yes 2 No |
| with the Maryland ns 23a or 28a-f show be notified at once. | Qι | 10e. Street and Number | nary 5 | | Calli | T | 10f. Zip C | ode | | | | 10g. Citiz | en of Wh | at Cour | ntry? |
| th the M | | 22870 Piney V | Wood Circ | ele | | | 20 | 619 | | | | | U | S A | |
| ath with | Funeral | 11. Marital Status 1 Never Married 2 M | | ecedent Ever in Forces? | | | Decedent s, specify | | | | cify Yes or N ican, etc.) | lo- | 14. Race White | | can Indian, Black, |
| ifter der | by Fu | 3 Widowed 4 Div | 1 Yes | | 1[| | Yes 2X | .] No | specify: | | | 5 | Specify: | Wh | ite |
| 136 hin 72 hours af e. than "natural | | 15. Decedent's Education (Spe | cify only highest g | | | | s Usual Oo st of worki | | | | | 16b. K | ind of Bu | siness/li | ndustry |
| 5-0036 led within 72 hours after death with the Maryland itygiene. other than "natural", or items 23a or 28a-f ahe the Medical Es miner must be notified at once | Completed | Elementary/Secondary (0-12) | College | (1-4 or 5+) | |] | Disab | 1ed | | | |] | Disal | bled | l |
| | Be Co | 17. Father's Name (First, Middle, Douglas Wa | , | Sturgeon | | | | 18 | | s Name (I ckie | First, Middle Ra | | | ague | |
| D 21 should I is mar | | 19a. Informant's Name/Relations | ship (Type, Print) | | 19b. Ma | _ | | | | | ral Route Nu | | | | |
| and 2 sho realth and ttem 27 is | ŀ | Donald E. Spra | | 208 | o. Place of Dis | posit | ion (Name | of ceme | | | Calif Date | | | | Town, State |
| Baltimore, MD 21215 bemit: Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked of njury or other traumatic event, the | | 1 Burial 2 X Cremation 4 Donation 5 Other S | | from State Ma | crematory of ittingley ineral Ho | -Ga me | erpl ace) ardine ,P.A.C | r rema | tory | 02/1 | 1/201 | 2 Le | onar | dto | wn, MD |
| Baltimo permit. Page Department or Important: injury or oth | ı | 21. Signature of Funeral Service | Libersee | ٧ | 2: N | 2. Na [at | ame and A | ddress d | of Facility Gard | iner | Fune | ral H | lome, | _ P | A. |
| Physician | \dashv | 23a. Part I. Enter the disease, or | Tarolina that | | th. Do not ent | 15 er the | 90 For emode of | enwi dying, s | <u>ck S</u> uch as ca | t., ardiacor | Leona: respiratory a | rdtow rrest, shoo | n, M ck, or hea | 1D 2 | Approximate Interval |
| /Medical Examiner | | failure, List only one cause Immediate Cause (Final disease | | pine In | toxicat | ic | on | | | | | | | | Between Onset and Death |
| LAMIIIICI | | or condition resulting in death) | Due to (or as | s a consequence | e of): | | | | _ | | | | | | |
| | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | | s a consequence | of): | | | | | | | | | | |
| cuted and transit | Examiner | (Disease or injury that initiated events resulting in death) Last | Due to (or as | s a consequence | e of): | | | | | | | | | | |
| a a exe | /Medical | ■ UNPENDED | AMENDE | 23a,27, | 28a-f, | рe | r me, | g92 | 6 4- | 16-1 | 2 sm | | | | |
| Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physicipage 2 should be detached for use as the burily | n/Me | IF FEMALE: 23b. Was decedent pregnant in the | | s, outcome of pre- | | Feta | al death | 3 | Ectopic | pregnan | су | | . Date of Month | | ay Year |
| Box 68 e death certiff the attending ed for use as t | Physician | past 12 months? 1 Yes 2 No 9 Uni | 4 Pre | gnant at time of | | | er (Specif | | | | | | | | - |
| by the a | F. | Part II. Other significant condit | 9 011 | nown to death but no | t resulting in th | ne un | nderlying c | ause giv | en in Par | rt I. | 23e. Did | tobacco u | se contri | bute to t | the cause of death? |
| ires that the signed by the detuched | ē ē | | | | | | | | | | 1 Y | es 2 | No 3[| Prob | ably 4 V Unknown |
| of Vital Records, ng Physician: The law requir ther this certificate has been is meral director, page 2 should | Completed | | | | | | | | | | | opsy |] p | nior to c | topsy findings available ompletion of cause of |
| Reco The law icate has | E | | | | | | | | | | 1 ✓ Yes | formed? | | leath? ✔ Ye | s 2 No |
| lital Resident The is certificate lirector, page | Be | 25. Was case referred to medica examiner? | Hospital: | Inpatient 2 | ✓ ER/Outpati | ent | | 10 | of Death (| | | Resider | nce 6 | Other | |
| of Villing Physic | ٩ | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Da | ite of Injury | 28b. Time | | jury 28 | | at Work? | | 8d. Describe | how inju | ry occurre | ed | |
| Division In or Attendi rs after death. al Director: | atio | 1 Natural 5 Pend 2 Accident Inve | ding stigation fd | 2-10-12 | fd 1:0 | _ | аш | | es 2 🗶 | | unkno | | J \$1 | | eel Doods North as City |
| Divis | Certification: | | ld not be 28e. Pl emined (Specia | ace of Injury - Al fy) I | Residen | | | mice bu | ilaing, etc | - 1 | or Town, Califo | State) 2. | 2870 | Pin | ral Route Number, City ey Wood Cir |
| Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: / | Medical C | 29a. Certifier (Check only 1 Certifying P | hysician: To the burniner:On the bas | is of examination | | | | | | ce, and d | lue to the car | use(s) and | manner | | |
| To witi | Me | 29b. Signature and title of certifi | and manne | r stated. | | | 29c. | License | nu m ber | | | 29d. D | ate signe | ed (Mor | nth, Day, Year) |
| | | AllenBu | roulf, 11 | 10 | | | | O.C.N | I.E. ——— | | | Febr | ruary 1 | 0, 201 | 2 |
| | | Name nd address of persor Melissa Brassell, MD | | ause of death (Ite ledical Exan | | W. | Baltimo | ore St | reet, Ba | altimore | e, MD 212 | 223 | | | |
| | | 31. Date filed (Month, Day, Year) | | Registrar's Sign | | | w | | | | | | | | |
| Regist | | FEB 1.4 | FAIT TO | - maria | ORIGII | 100 | | | | | | | | | |
| OCME 2006 | JU 1 | Ser op 183 ha | | | ORIGII | 4WL | • | | | | | | | | |

Britany M. Michaels Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day February 4, 2012 1333 hrs Medical Examiner BRITTANY MARGARET MICHAELS 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Queen Anne's Route 544 & Route 301 Millington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 1 M 2 X F MARYLAND 10/16/1985 213-11-5088 26 Usual Residence of Decedent iny 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits 1 Yes 2 XNo 28a-fahor s 23a or 28a-f sho e notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. rector **OUEEN ANNE'S** MILLINGTON 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 308 MIDDLE STREET UNITED STATES 21651 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No 1 Yes f Yes, Give Year Specify: WHITE 3 Widowed 4 Divorced Yes 2 X No specify: ≦ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 WAITRESS RESTAURANT 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) the nent of Health and Mental Hy unt: If item 27 is marked o Be JAMES JOSEPH ANDERSON LIZBETH MARLENE BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 19a. Informant's Name/Relationship (Type, Print.) JAMES J. ANDERSON / FATHER 314 BLANCO ROAD MILLINGTON, MARYLAND 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State permit. Page:
Department o
Important: 02/12/2012 STEVENSVILLE, MARYLAND 4 Donation 5 Other Specify CHESAPEAKE CREMATION 늄 21. Signature of Funeral Service Lice 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER-ROAD CHESTERTOWN, MARYLAND 21620 23a. Part I. Enter the disease, or complexitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Head Injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and cian/Medical AMENDED 23a, 27, 28a-f, per me, g924 2-23-12 sm X UNPENDED attending physician for use as the burial Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death 1 Live birth Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. á 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has death? performed' this certificate Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 🗸 Yes 2 No 28d. Describe how injury occurred **Driver of a** car that intentionally collided with a tractor—trailer After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 1 Yes 2K No I Director: 5 Pending death. fd 2-4-12 fd 1:30 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number or Town, StateRt 544 and Rt 301 M111ington, Md. street, factory, office building, etc 24 hours after of Funeral Direc 28e. Place of Injury - At h 3 X Suicide 6 Could not be major highway determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

DHMH 17 Rev 1/2001 **OCME 2006**

State Registra

To the within 2

29b. Signature and title of certifier

Pamela E. Southall, MD

HITHER

30. Name and address of person who completed cause of death (Item 23a)

strar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d, Date signed (Month, Day, Year)

February 5, 2012

12-00870 Kelly Mohen Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 04729 Certificate of Death Reg. No 1. For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Lest) Month Day January 29, 2012 Physician/ 1630 hrs Medical Examiner KELLY ANNE MOHEN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 109 South Durham Street B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Country) Funera! Months Davs Hours PA 09/11/1971 Director M 2 X F 40 188-60-4788 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b Count any 1 Yes 2 X No 28a-f show BALTIMORE BALTIMORE imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? Director 10f. Zip Code 10e Street and Number UNITED STATES 109 SOUTH DURHAM 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 2 X No WHITE Specify: 1 Yes 2 X No specify: If Yes, Give Year Widowed Divorced 16b. Kind of Business/Industry ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) HEALTH CARE NURSE 12 1B Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SUZANNE MARIE PURCELL Be LEE FRANCIS MOHEN, (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) 109 LINDSAY ROAD MILLINGTON, MARYLAND 21651 DOMINIQUE MOHEN / SISTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from Stat Department o Important: injury or oth 02/06/2012 STEVENSVILLE, MARYLAND CHESAPEAKE CREMATION Donation 5 Other Specify 22 Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERL HOME, P.A.
370 W. CYPRESS ST. MILLINGTON, MD 21651 21. Signature of Funeral Service Licensee Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death a. Combined Effects of Methadone, Alprazolam and Promethazine Medical Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical physician the burial -23d. Date of delivery 68760 23c. If yes, outcome of pregnancy IF FEMALE Day Year 3 Ectopic pregnancy Month 23b. Wes decedent pregnant in the Fetal death Live birth 2 by the attending ached for use as t past 12 months? Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 No 9 V Unknown ю Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I signed by the be detached Part II. Other significant conditions o 1 Yes 2 No 3 Probably 4 V Unknown ş σ. 24b. Were autopsy findings available Completed 24a. Was an Records, prior to completion of cause of been page 2 should autopsy death? performed has 2 No 1 🗸 Yes ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Nursing Home 5 Residence 6 Other: Scene examiner ER/Outpatient 3 DOA Inpatient 2 this 1 V Yes ٩ 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death After Subject took medications FOUND: Yes 2 V No 1 Natural Division Pending Director: 1625 hrs death. Jan 29, 2012 2Bf. Location (Street and Number or Rural Route Number, City 2 🗸 Accident Investigation 2Be. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 109 South Durham Street, Baltimore, MD Could not be hours after 3 Suicide (Specify) Townhouse / Rowhouse determined within 24 hours a 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier January 30, 2012 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Carol Allan, MD 200 31. Date filed (Month, Pay Year) State

Registra

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27, 2012 January 7:04a Moussiaux L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Woodbine 1372 Hoods Mill Road . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) Director 25 213-19-3238 1 M 2 X F Yrs. June 27, 1986 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City. Town or Location with the Maryland Director 1 Yes 2 K No Maryland Carroll Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21797 1372 Hoods Mill Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Computer Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Shirley Savitts John Moussiaux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1372 Hoods Mill Road, Woodbine, Maryland 21797 Ryan Pickett/ Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of F. Important: If ite any injury or other 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Morgan Chapel Cemetery1/31/2012 Woodbine, Maryland. 22. Name and Address of Facility
Stauffer Funeral
1621 Opossumtown 21. Signature uneral Servi Homes P. A. Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition ancel Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician thed for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Cther (specify) 1 Live Birth 2 Li retailuea 4 Pregnant at time of death in the past 12 months? Month Year

To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760

၉

Medical Certificate:

29b. Signature and title of certifier

Mark Miller

31. Date filed (Month, Day, Year)

| 9 Unknown | 9 Unknown | |
|---|---|---|
| Part II. Other significant conditions o | ontributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| | | 24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No |
| 25. Was case referred to medical | 26. Place of Death (Check | only one) |
| examiner? 1 🗆 Yes 2 💢 No | Hospital: 1 | me 5 Residence 6 Other (Specify) |
| 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | (<i>Month, Day, Year</i>) injury work? M 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred |
| 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| (Check 2 Medical Exam | sician: To the best of my knowledge, death occurred at the time, date and place, ar iner: On the basis of examination and/or investigation, in my opinion, death occurred at se)Practitioner: To the best of my knowledge, death occurred at the time, date and pla | the time, date and place, and due to the cause(s) and manner stated |

14172549

1/30 /20R

State Registrar

MD 2411 West Belvedere Avenue, Suite 206, Baltimore MD 21215 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

3

32. Registrar's Signature

Hell

Highway, Crefield MD 21817

David Vanryswick
12-01176
Physical Property Part Unit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| . , , , | | | • |
|---------------------|------------------|----------------|------------|
| State of Maryland / | Department of He | ealth and Ment | al Hygiene |

| 2 | 0 | - | 2 | 0 | 1 | 7 | 3 | 2 |
|------|--------|----|--------|---|---|---|---|---|
| Same | \sim | 19 | 40.000 | | | | | |

| | | I- For State Registrar | Certific | ate of De | ath | | F | Reg. No. | |
|---|----------------|---|------------------------|-------------------|----------------------------------|------------------------------|---|-----------------------------|--|
| Physicia | ın/ | 1. Decedent's Name (First, Middle,Last) | | | | | 2. Date of Dea Month | Day Year | 3. Time of Death |
| Medical Exami | | David Van Ryswick | | | | | February | | 2346 hrs |
| | | 4a. Facility Name (if not institution, give street and numb | er) | | y, Town, or Lo | ocation of De | ath | 4c. County of Dea | ath |
| | | 45955 Fox Chase Dr Apt. 801 | | | | W11-4-404 | Use IO Date of P | irth (MM/DD/YYYY) 9. E | Pirthulana (State or |
| Funeral | | 5. Social Security Number 6. Sex 7. | Age (In yrs. last bir | ,, | nder 1 Year | | Aira | For | eian I |
| Director | | 216-76-3876 1x M 2 F | 56 | Yrs. | | | 02/08 | /1956 | Country)Maryland |
| À | | Usual Residence of Decedent | 10c. City, Town | ar Location | | | | | 10d. Inside City Limits |
| w any | | 10a. State 10b. County Maryland ST. Mary's | Toc. City, Town | TOT LOCATION | Great | Mills | | | 1 Yes 2 X No |
| Maryland 28a-f show d at once. | ē | | | 1.01 | | | | 10g. Citizen of What Co | |
| Mary 28a | Director | 10e. Street and Number | | 107. | Zip Code | | | | ountry ? |
| h the | | 45955 Fox Chase Drive # | | | 2063 | | | USA | vices to the Direct |
| death with the Maryland or items 23a or 28a-f sho must be potified at once. | Funeral | 11. Marital Status 1 Never Married 2 Married Armed Force | | 13. Was Dec | edent of Hispa ecify Cuban, N | anic Origin? Mexican, Pue | (Specify Yes or N erto Rican, etc.) | White, etc. | erican Indian, Black, |
| 면 등 점 | 교 | 1 Yes | 2 X No | 1 Yes | No. | specify: | | Specify: | White |
| 5-0036 led within 72 hours after ffygiene. other than "natural", (the Medical Examiner) | à | Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade) | completed) 16a | Decedent's Usi | ~ | | of work done | 16b. Kind of Busines | |
| hour Exa | ted. | Elementary/Secondary (0-12) College (1-4 | , | during most of | | | | | |
| 36 Din 73 | Completed | 12 | ŕ | Dis | abled | | | Disab | led |
| 1 -0 -0 -0 -0 -0 -1 | 팃 | 17. Father's Name (First, Middle, Last) | | | | 3.Mother's Na | ame (First, Middle, | Maiden Surname) | |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica | Be | Joseph Francis Van Rys | wick | | | Mary 1 | Frances : | Teresa Beal | .1 |
| 2121(ould be fill Mental H marked ic event, i | 흔 | 19a. Informant's Name/Relationship (Type, Print) | 19 | | | | | mber, City or Town, Sta | |
| MD d 2 sho lth and n 27 is | | Jennifer Ann Henderson/D | | | | | | | |
| ore, MD ges I and 2 sh t of Health and: If item 27 in ther traumat | | 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from | | of Disposition (I | | etery, | Date | 20c. Location - City | or Town, State |
| TO ages | | 4 Donation 5 Other Specify: | State | ate Heart | - | у 0: | 2/15/2012 | 2 Lexington | Park, MD |
| Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental Hi Important: If item 27 is marked of injury or other traumantic event, the | 1 | 21. Signature of Funeral Service Linnsee | | 22. Name a | ind Address o | 4 Families | | | |
| E E E | 2 5 | Michael & Jardines |) | 4150 | Fenwic | k Str | eet Leon | ardtown, MD | Home, P.A. 20650 |
| Physician | | 23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line. Chro | ed the death. Do n | ot enter the mo | te of dying, su | uch as cardia | ic or respiratory ar | rest, shock, or heart | Approximate Interval Between Onset and |
| Medical. Examiner | | Immediate Cause (Final disease a.by Therm | | | ruimor | idly D | | ompifeaced | Death |
| - ZAGIIIIIO | - 1 | or condition resulting in death) Due to (or as a co | insequence of): | | | | | | |
| | 닓 | Sequentially list conditions, if any, leading to immediate | distantance of: | | | | | | |
| | 틭 | cause. Enter Underlying Cause | | | | | | | |
| d d | Examiner | events resulting in death) Last Due to (or as a co | insequence of): | | | | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | | dd | a,27,28a- | -f per r | ne a925 | 5 3-7- | 12 cm | | |
| 7 60, cate be ex physician he burial | Medical | | | | | <i>J J</i> - <i>I</i> - | 12 511 | | |
| 766 ficate g phy s the t | | 23b. Was decedent pregnant in the | come of pregnancy | | ath 3 | Ectopic pre | gnancy | 23d. Date of deliv Month | ery Day Year |
| Box 687 e death certific the attending p | Physician/ | | t at time of death | 5 Other (S | _ | | 3 , | | , |
| Box e death the att | ysi | 1 Yes 2 No 9 Unknown 9 Unknown | 1 | | | | | | |
| that the ned by t | | Part II. Other significant conditions contributing to d | eath but not resulting | ng in the underly | ring cause giv | en in Part I. | | tobacco use contribute | |
| , P.O. res that the signed by be detack | d by | | | | | | _ LY | es 2 No 3 P | robably 4 🏏 Unknown |
| ords, | Completed | | | | | | 24a. Was | | autopsy findings available o completion of cause of |
| e law e has ge 2 s | E | | | | | | perf | ormed? death 2 No 1 ✓ | ? |
| tal Rectant The certificate ector, page | | 25. Was case referred to medical | | | 26.Place o | of Death (Che | | 2 10 1 | |
| Division of Vital Records, tal or Attending Physician: The law require rs after death. *I Director: After this certificate has been sited in by the funeral director, page 2 should be | B | examiner? [Hospital: 1] lon | atient 2 ER/0 | Outpatient 3 | DOA O | ther ₄ Nu | rsing Home 5 | Residence 6 🗸 Ot | ner: Scene |
| Ing Physi After this funeral dir | P | 27. Manner of Death 28a. Date of | Injury 28b | Time of Injury | 28c. Injury | | | how injury occurred | |
| Ith. Af | 틸 | 1 Natural 5 Pending fd 2- | | 11:46 рп | 1 Ye | es 2 🗷 No | subject fire | t victim of | dwelling |
| isic recto | <u>S</u> | 28e. Place of | of Injury - At home, | | | ilding, etc. | 28f Location | (Street and Number or | Rural Route Number, City |
| Division pital or Atten ours after death neral Director: | Certification: | 3 Suicide 6 Could not be determined (Specify) | Res | sidence | | | Apt 80 | State)4955 Fox 1 Great M | ills,MD. |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the | | 29a. Certifier 1 Certifying Physician: To the best of | f my knowledge, de | eath occurred at | the time, date | e and place, | and due to the cau | use(s) and manner as s | tated. |
| To the Hos within 24 h To the Fur completely | Medical | one) 2 Medical Examiner: On the basis of and manner stal | examination and/or | investigation, ir | my opinion, | death occurr | ed at the time, date | e and place, and due to | the cause(s) |
| F F F S | Z E | 29b. Signature and title of certifier | | | 29c. License | number | | 29d. Date signed (f | |
| | | 00- | | | O.C.M | I.E. | | February 9, 20 | 12 |
| | | 30. Name and address of person who completed cause | of death (Item 23a) | | | <u> </u> | | | |
| | | Donna M. Vincenti, MD Assistant Me | dical Examine | r 900 W. E | Baltimore S | Street, Ba | ltimore, MD 2 | 1223 | |
| | ate | | strar's Signature | back | / | | | | |
| Regis | trar | FFR 1 4 2012 Z | me p. | | | _ | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1255 DM hll Medical ity Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Min 12/04/1927 PENNSYLVANIA Director 216-22-8983 84 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 XNo MD QUEEN ANNE'S CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 DRAKE ROAD UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married X Yes by 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other two. 12 4 **MICROBIOLOGIST** U.S. GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ALBERT ROSENWALD MARGARET HARTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JULIA ROSENWALD / WIFE 102 DRAKE ROAD CHESTERTOWN, MARYLAND 21620 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 01/27/2012 STEVENSVILLE. MARYLAND of Funeral Service Licenses 21. Signature 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND Kelly 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ DISEASE BULLOU disease or condition Medical resulting in death) Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 No Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No illed in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHESKLTOWN BROW 21620 1205 TROCKT 100 31. Date filed (Month, Day, Year, 32. Registrar's Signature State IAN 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 8:04 a M lema Medical 4a. Facility Name (if not institution, give street and nur 4b. City, Town, or Location of Death **Examiner** 4c. County of Death OKT PONUSIT 30 Haiman Lane CECIL Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Country) Maryland 1 X M 2 □ F Days Min Oct. 28, 1933 212-30-5015 78 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland al Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Port Deposit Maryland Cecil 1 Yes 2 TNNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Haiman Lane 21904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1953-54 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: "natural", Specify: Completed 3 Divorced 4 Divorced White injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) ll Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Two Years U.S. Army U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H is marked ot George Kenneth Reiblich Georgiana Blanchard Tufts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 str Department of Health ar Important: If item 27 is any injury or other trau Anne R. Leland (sister) 12015 Belair Road, Kingsville, Maryland 21087 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State cemetery, crematory or other place, R.A. Ferris & Co., Inc. 01/31/12 Pennsylvánia 4 Donation 5 Other (Specify) Lee A. Parterson & Son Funeral Home, P Perryville. Maryland 21903-0766 21. Signature of Funeral Service Linens, e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ ASPIRATI disease or condition Medical resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a co law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CENERIO - VACENTAL Decreer 1 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24b. Were autopsy findings available CALOTO SPENOSUS 24a. Was an 1as prior to completion of cause of death? performed certificate 2 No Yes 2 🗆 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 Hospital: Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00020390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21902 4+111 PUINT VA MERACO HOESCIA MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

| | | Plea | ase Type or | | | | | | | | egible | |
|---|------------------|--|--|-----------------------------------|---------------------|---|---------------------------|--------------------------|---------------------------------|--------------|---------------------------|------------------------------------|
| | | For State Registrar | State of | r iviaryian | | artment of F tificate of L | | and iv | , | Reg. No. 2 | 012 | 04735 |
| Physicia | / | Decedent's Name (First, Middle) | e, Last) | | | | | | 2. Date of Dea Month | th | Voor | 3. Time of Death |
| Physicia Medio | al | Leslie Ann Ree | | | | | | | Januar | | 2012 | 9:58a [™] |
| Examin | er | 4a. Facility Name (if not institution | | per) | | 4b. City, Town, or | | | | 4c. Co | unty of Dea | |
| Funeral | | Citizens Care a 5. Social Security Number | | 7. Age (In yrs. la | ast birthday) | If Under 1 Year | deric | 24 Hrs. | 8. Date of Birth | | | ederick thplace (State or Foreign |
| Director | | 332-52-3767 | 1 □ M 2 🕱 F | 56 | Yrs. | Months Days | Hours | Min. | (Month, Day | | | untry) |
| show dat | r | Usual Residence of Decedent 10a. State 10b. County | | | y, Town or Loc | cation | | | Nov.8 1 | 900 | M | aryland 10d. Inside City Limits |
| farylar Ba-f s tiffed | ecto | Maryland Fred | erick | | derick | | | | | | | 1 🎇 Yes 2 □ No |
| the Na or 28 | Funeral Director | 10e. Street and Number | CIICK | 110 | <u>uclick</u> | 10f. Zip Code | | | | 10g. Citizen | of What Co | ountry? |
| h with | nera | 2406 Ellsworth | Way Unit | l – B | | 2 | 1702 | | | Un | ited S | States |
| r deat ir iten iiner r | | 11. Marital Status 1 □ Never Married 2 □ Mar | 12. Was Deced | ces? | | Vas Decedent of Hi f Yes, specify Cuba | spanic Orig n, Mexican | gin? (Spec , Puerto F | cify Yes or No- Rican, etc.) | | Race - Ame Black, Whit | erican Indian, e, etc. |
| s after ral", o Exam | ed by | 3 ☐ Widowed 4 🔀 Divorced | 14 V Civia | | 1 | ☐ Yes 2 🖾 No | Specify: | | | Spe | ecify: Wh | nite |
| hour "natu dical | plete | | nt's Education est grade completed) | | 16a. Deced | lent's Usual Occup | ation | of working | 200 | 16b. Kind | of Business | /Industry |
| thin 72 ane. than a | Completed | Elementary/Secondary (0-12) | College (1-4 | 4 or 5+) | life. DO | O NOT use retired) | 9 | OI WOIKII | 'g | .11±. | - 1 C | |
| led wi Hygie other ent, tl | Be (| 17. Father's Name (First, Middle, I | .ast) | | | Accounti | 0 | r's Name | (First, Middle, N | | | rvices |
| d be fi dental irked tic ev | 욘 | Raymond Reese | | | | | | | Smith | | | |
| should and N is ma auma | | 19a. Informant's Name/Relations | nip (Type, Print) | | 19b. Mailin | g Address (Street a | and Number | r or Rural | Route Number, | City or Tow | ın, State, Zij | o Code) |
| and 2 lealth | | Rosalie Reese/ | Mother | | | Ellswort | h Way | Uni | t 1-B F: | | | |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at one. | | 20a. Method of Disposition 1 Description 2 Cremation | | State C | emetery, crem | sition (Name of natory or other plac | | | ate | | • | Town, State |
| artme ortan injury e. | | 4 Donation 5 Other (S | idens d e | St | | Cremato: | | | | | erick, | Maryland. |
| Der Imp any | | * Jode X | HILME | \mathcal{M} | / \ \s\\\16 | Name and Addres tauffer F 21 Opossi | unera | il Ho n Pil | mes P. ke, Fre | A. dericl | k,Mary | vland 21702 |
| TO SE | | 23a. art 1. Enter the disease, or shock, or heart failure. List of | complications that ca | used the death | | _ | _ | cardiac or | r respiratory arre | est, | | Approximate Interval Between |
| Physician/ | | Immediate Cause (Final disease or condition | m | ultipl | ر د | Silero | 212 | | | | | Opeet and Death |
| Medical Examiner | | resulting in death) | Due to (o | r as a consequ | ience of): | | | | | | | 7 |
| 3 6 3 | Jer | Sequentially list conditions, if any, leading to immediate | b. — Due to (o | r as a consequ | ience of): | | | | | | | |
| uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | 6 | | | | | | | | | |
| executed ian and urial-transi | _ | resulting in death) Last | Due to (o | r as a consequ | ience of): | | | | | | | |
| cate be executed physician and the burial-transit | Physician/Medica | | d | | | | | | | | | |
| aath certifica attending pl | /M | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outco | ome of pregna | ncy | | | | | 224 | Data of do | livani |
| eath c e atter d for u | icia | in the past 12 months? 1 Yes 2 No | 4 Pregna | irth 2 🗀 Feta ant at time of d | | Ectopic pregnanc Other (specify) | У | | | 230 | . Date of de Month | Day Year |
| t the d by the stache | Phys | g 🗆 Unknown | 9 L Unkno | | | | | | - | | | |
| Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu | ρ | Part II. Other significant condition | ns contributing to dea | ath but not res | ulting in the ui | nderlying cause giv | en in Part I. | | 23e, Did tol | V | | the cause of death? |
| requir been s should | Completed | | | | | | | | | | | topsy findings available |
| The law ate has I page 2 s | ldmc | | | | | | | | 24a. Was a autops perfor | sy | prior to death? | completion of cause of |
| ilcian: The certificate rector, pag | Be Co | 25. Was case referred to medical | | | | 26. Pla | ace of Death | h (Check | 1 \(\superstack \text{Yes}\) | 2 No | 1 🗌 Yes | s 2 No |
| r Physician r this certi eral directo | To B | examiner? 1 Yes 2 No | Hospital: 1 ☐ Ir | npatient 2 🗆 | ER/Outpatien | Othe | er: 1 | | ne 5 🗆 Reside | ence 6 🗆 | Other (Spec | ify) |
| ing Pt | | 27. Manner of Death 1 Natural 5 □ Pendin | 28a. Date of (Month | f injury , <i>Day, Year)</i> | 28b. Time of injury | 28c. Injury work | ? | | 8d. Describe ho | w injury oc | curred | |
| Attend death ctor: / | Certificate: | 2 Accident Investig 3 ☐ Suicide 6 ☐ Could | not be | of Injury - At ho | me farm stre | M 1 L | Yes 2 🗆 | | 28f Location /St | root and Nu | mbar or Pu | ral Route Number, |
| al or A s after I Direct | | 4 Homicide determ | | g, etc. (Specify) | | et, factory, office | | - | City or Town | | irriber or nu | rai noute Numbei, |
| To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral | Medical | (Check 2 _ Medical E | Physician: To the best | of examination | and/or investi | igation, in my opinio | n, death occ | curred at | the time, date an | d place, and | due to the | cause(s) and manner stated. |
| To the vithin To the compl | 2 | only one) 3 Certifying 29b. Signature and title of certifier | Nurse Practitioner: | / During pest of m | iy kilowieage, | 29c, License | number | | 2 | | | s stated. n, Day, Year) |
|) | | Asker ! | X. Varia | run | 00=1/27 | | _/3 | 10 | | / | 130 | 112 |
| ム | | 30. Name and address of person was Robert L. Kau | 1 | of death (Item | | , | Fred | derio | ck. Mary | /land | 21701 | |
| Stat | | 31. Date filed (Month, Day, Year) | | jistrar's Signat | ure | * | , | | | , | | |
| Registra | r | | - LUIL | yearan_ | 13. Ja | arket | | | | | | |

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

| | | For | Plea | | | | | | | | | All Copie Mental Hy | | | egible. | | 736 |
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| Physicia | n/ | State Registrar 1. Decedent's Name | e (First, Middle | · / | | | | rtificat | e of D | eath | | 2. Date of D | | | Year | 3. Time o | f Death |
| Medic Examin | al | 4a. Facility Name (if | not institution, | | | | Slifer | _ | Town, or | Location | of Death | Februa | | | 2012 unty of Deat | 2:35 | P M |
| Funeral | | Genesis 5. Social Security N | | e View | | ge (In yrs. I | ast birthday) | If Unde | | If Under | | 8. Date of B | irth | | ederi | thplace (State of | or Foreign |
| Director | | 217-12-2 Usual Residence of | | 1 🗆 M 2 | X F | | 8 Yrs. | Months | Days | Hours | Min. | (Month, D Sept. | 12 , | 19 | 2R | ryland | 24 . I I 14 |
| Marylan 28a-f sh otified a | Director | Maryland | Frede | rick | | | derick | | | | | | | | | | 3 2 No |
| with the s 23a or ust be n | Funeral D | 700 Toll | | Avenu | ıe | | | 10f. Zip | Code 21701 | | | | _ | | of What Co | | |
| permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 11. Marital Status 1 | | ied Ar | as Decedent med Forces' Yes 2X Yes, Give ar or Dates. | ? | | Was Deced If Yes, spec 1 Yes | ify Cubar | n, Mexical | n, Puerto | ecify Yes or No Rican, etc.) |)- | | Black, White | rican Indian, e, etc. iite | |
| n 72 hour e. an "natu Medical | Completed by | | 15. Deceder | st grade con | | 5+1 | 16a. Dece (Give life. D | dent's Usu kind of wo O NOT use | rk done di | ation uring mos | at of work | ing | 16b. | Kind o | of Business | Industry | |
| led withi Hygiene other th ent, the | Be | Elementary/Second 17. Father's Name (i | | | ik.) | | H | Iomema | aker | 18. Moth | ıer's Nam | e (First, Middle | e, Maidei | | n Hom _{ame)} (u | ne ink.) | |
| ould be fi id Mental marked matic ev | 인 | 19a. Informant's Na | me/Relationsh | in (Type Pri | nt) | | 10h Maili | a a Addross | (Street o | | | al Route Numb | | | | - Codol | |
| and 2 shu Health an em 27 is ther trau | | Steven S | Slifer | | | T005 5 | | ancas | ster | | e, F | rederi | ck, | MD | 21703 | | |
| Page 1 tment of tant: If it jury or o | | 1 ☐ Burial 2) 4 ☐ Donation | Cremation 5 D Other (S | pecify) | al from Stat | e c | cemetery, crer thaver | natory or c | ther place nator | у | 2/2/ | | Fr | ede | rick, | Town, State Maryla | and |
| permit Depar Impor any in | | 21. Signature of Fur | neral Service L | icensee | | | R€ 95 | 2. Name ar esthav 501 Ca | d Addres 7en F 1toct | s of Facili uner in M | al S | ervice: | s, S | kko red | t Cod | y P.A. | 1701 |
| Physician/ Medical Examiner | | 23a. Part 1. Enter t shock or hear Immediate Cause (disease or condition resulting in death) | rt failure. List o Tinal | nly one caus | e on each lir | ne. | h. Do not ent | | | ı, such as | cardiac o | or respiratory a | arrest, | | | Approximatinterval Bet Onset and | ween |
| i = 6 | ical Examiner | Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or that initiated events resulting in death) I | nmediate rlying injury s | с | Due to (or as | | | | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the bu | Physician/Medica | IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown | months? | 1 4 | res, outcome Live Birth Pregnant Unknown | 2 Feta at time of o | aldeath 3 | ☐ Ectopic ☐ Other (sp | | / | | | | | Date of de Month | | Year |
| ires that ti signed by Id be deta | | Part II. Other signif | ficant condition | ns contribut | ng to death | but not res | sulting in the o | underlying | v A | en in Part | I. | | | | | the cause of d | |
| The law requate has beer page 2 shou | Completed by | hyper | ii _ | Reda | uy a | ises | w | | | | | | opsy formed? | | prior to death? | topsy findings completion of c | available cause of |
| ysician: s certific director, | To Be | 25. Was case referre examiner? 1 Yes 2 | | Hospita | l: 1 🗆 Inpa | tient 2 🗆 | ER/Outpatie | nt 3 🗆 D | Othe | | | k only one) | sidence | 6 🗆 (| Other (Spec | ifv) | |
| iding Phy th. : After thi e funeral | | 27. Manner of Death 1 XXIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII | 5 Pendin | g | a. Date of inj (Month, D | ury | 28b. Time of injury | | 8c. Injury work? | at | | 28d. Describe | | | | oy) | |
| al or Atter s after dea n Director ed in by the | l Certificate: | 3 Suicide 4 Homicide | 6 Gould r | not be | | jury - At ho tc. (Specify | ome, farm, str | eet, factory | | | | 28f. Location City or To | | | mber or Ru | ral Route Numb | per, |
| ne Hospit n 24 hour ne Funera pletely fills | Medical | (Check 2 | | xaminer: On | the basis of | examination | n and/or inves | tigation, in | my opinio | n, death o | ccurred at | | and plac | ce, and | due to the | cause(s) and ma | inner stated |
| To the within com | | 29b. Signature and | title of certifier | CR: | nP. | A | | | License | | | | 29d. D | ate sig | ned (Month | n, Day, Year) | |
| | | 30. Name and addre | Pieri | | Marsh | alee_ | Drive, | | idge | , MD | 210 | 75 | | | | | |
| Stat Registra | | 31. Date filed (Monti | | 2012 | 32. Regist | rar's Signat | ture. | arke | / | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Month Physician/ 150 AM EDITH ELIZABETH SMITH so by vacu Medical Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ty Dal timore a Hospi tal of 1 timere Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours **Director** 216-70-6299 1 🗆 M 2 🗶 F 53 01/19/1959 MARYLAND Usual Residence of Decedent show or 28a-f show 10b. County Oa. State 10c. City, Town or Location 10d Inside City Limits death with the Maryland Director 1 Yes 2 X No MD KENT WORTON ō 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? items 23a or ner must be n Funeral UNITED STATES 25155 CHINOUAPIN ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian and Mental Hygiene. is marked other than "natural", or iter aumatic event, the Medical Examiner Armed Forces? Black White etc. þ 1 Never Married 2 Married 21215-0036 1 Yes 2 XNo Specify. If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER 12 OWN HOME Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked, any injury or other traumatic ew. ပ RALPH IRVIN MILLER, SR. NANCY LECATES GINN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES SMITH / HUSBAND 25155 CHINQUAPIN ROAD WORTON, MD 21678 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) KENNEDYVILLE CEMETERY 02/12/2012 KENNEDYVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Kit A. Hel SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Syste MOIH dou disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phase as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atte in the past 12 months? Month Dav Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? certificate Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State

Registrar

6

(Check

only one)

31. Date filed (Month.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 🙀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month January 0414 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death hester e11 101 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Mir Days 08/10/1942 PENNSYLVANIA Yrs **Director** 163-34-7963 69 Usual Residence of Decedent show 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified at 28a-f 1 Tes 2 X No MD QUEEN ANNE'S SUDLERSVILLE 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1112 DUHAMEL CORNER ROAD UNITED STATES 21668 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' Black, White, etc. ō þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: WHITE "natural", 3 Divorced 4 Divorced Completed 1970 the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 SERGEANT T.AW Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ JOSEPH LEWIS SIDLOW LILLIE CHURRICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. 1112 DUHAMEL CORNER ROAD SUDLERSVILLE, MD 21668 JOYCE A. SIDLOW / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) NEW GARDEN FRIENDS CEM. 02/04/12 AVONDALE, PENNSYLVANIA 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 370 W. CYPRESS ST. MILLINGTON, MD 21651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between ARONIC Onset and Death Immediate Cause (Final Physician/ OSSPRUCTIVE D. Setts disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 2 No မ 1 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death. neral Director: After 1. Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation completed filled in by the Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 24 hours Medical 29a. Certifier 🖂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title of certifie 29d. Date signed (Month, Day, Year) MP 30 00 5

State Registrar er,

31. Date filed (Month

Brown

rar's Signature

CHESTERTOWN

21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

146031

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

| | | | Plea | | | | | | | | | II Copie | | _ | jible. | |
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| | For State | . | | St | ate of I | Marylan | | artment <i>tificate</i> | | | and N | 1ental Hy | /gien Reg. I | 2.0 | 12 | 04739 |
| | | nt's Name | (First, Middle | | | | 007 | imouto | 0, 0 | Catri | | 2. Date of De | eath | 10. 125 | | 3. Time of Death |
| Physician/ Medical | <u> </u> | | | CHEID | | | | | | | | JANUAI | RY 2 | 23, 2 | 012 | 2:02 p M |
| Examiner | Anr | ne Ar | ot institution, undel | Medic | | | | | apol | | of Death | | 4 | 4c. County An i | of Death | rundel |
| Funeral Director | 1114 | 32–25 | | 6. Sex | | Age (In yrs. Ia 71 | as <i>t birthday)</i> Yrs. | If Under 1 Months | Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bii (Month, Da Dec 22 | rth ay, Year 2 19 | 40 | g. Birth Court Penr | place (State or Foreign otry) nsylvania |
| show dat | | | 10b. County | | | | y, Town or Loc | | | | | | | | Ţ. | 10d. Inside City Limits |
| e Mary r 28a-f notifie | PA 10e. Street | | Delaw | vare | | Bro | okhave | | 2 1 | | | | | | | 1 Yes 2 No |
| th with the Maryland ns 23a or 28a-f show must be notified at meral Director | 410 | | odland | Ave. | | | | 10f. Zip (| 015 | | _ | | | Citizen of V | | ntry? |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | 11. Marital 3 | ver Marrie | d 2 K Marr | ried 1 | as Deceder med Forces Yes 2 Yes, Give ear or Dates | | " | Was Decede f Yes, specif i Yes 2 | y Cuban | n, Mexicar | gin? (Spe ı, Puerto | cify Yes or No- Rican, etc.) | - | Blad | e - Americ ck, White, Whi | |
| 2 hours "natur edical I | | (Speci | 15. Deceder | nt's Educatio | n | | 16a. Deced | lent's Usual kind of work | Occupa | ition | of worki | na | | Kind of B | | dustry |
| vithin 7 iene. | Element | | dary (0-12) | | ollege (1-4 c | or 5+) | life. DO | 0 NOT use r inting | retired) | | | | | lasti anufa | | er |
| To Be | 17. Father's | | rst, Middle, L Thomas | | ier | | | <u></u> | | 18. Moth | | (First, Middle | | | | |
| d 2 should ealth and M n 27 is ma er trauma | | | e/Relationsh • Sche | | | band) | 19b. Mailin 4106 | ng Address (| Street a | nd Numbe | er or Rura • B | Route Number | er, City V en | or Town, S | State, Zip (1901 | Code) 5 |
| Page 1 an nent of He ant: If iten ıry or oth | | Burial 2 🔀 | sition Cremation Dother (S | | val from Sta | rite R.A | lace of Dispo emetery, cren Ferr | sition (Name natory or oth is Cr | e of ner place emat | ory | | 8/12 | | | - | own, State |
| permit. Departr Importa any inji | 21. Signatu | ire of Fune | eral Service I | 2 | | M0051 | 0 M | Name and Iinsha Iiddle | Address 11 S town | s of Facilit Shrop | shir Kno | e-Bleyl wlton B | ler Rds. | Fune: Med | ral H | Tome PA. 19063 |
| Physician/ | Immediate disease or | k, or beart Cause (Fi condition | failure. List o nal | | | | | | | | | r respiratory a | | | | Approximate Interval Between Onset and Death |
| Medical Examiner | resulting in | (death) | - 1 | f a. – | Due to (or a | as a consequ | ience of): | , | | • | | | | | | |
| ecuted al-transit | Sequential if any, lead cause. Ent Cause (Dis | ling to imn ter Underly | nediate ring | b. — | Due to (or a | as a consequ | ience of): | | | | | | | | | |
| = E = 6 | | ed events | | C. — | Due to (or a | as a consequ | ence of): | | | | | | | | | |
| ificate ng phys as the | IF FEMALE: | | | d | | | | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral Certificate: To Be Completed by Physician/Medical | 23b. Was do in the p | | onths? | 1 4 | Live Birt | t at time of c | death 3 | Ectopic production of the Control of | | ′ | | | | | te of deliventh | ery Day Year |
| uires that the signed by all be deta | Fait II. Otik | er signific | ant conditio | ns contribut | ing to death | but not res | ulting in the u | nderlying ca | ause give | en in Part | l. | | | | | ne cause of death? |
| sician: The law requires certificate has been significate, page 2 should be be been been been been been been be | | | | | | - | | | | | | 24a. Was auto perfe | | | | psy findings available mpletion of cause of |
| certifica ector, p | 25. Was cas examine | er? | | Hospita | 31: 4 | | | | | ce of Dea | th (Check | | | | | |
| ng Physi ter this c ineral dir | | of Death | 5 Pendin | 28 | a. Date of ir (Month, L | njury | ER/Outpatien 28b. Time of injury | | Other c. Injury work? | at Nu | | me 5 Resi 28d. Describe | | | |) |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certificate: To Be (| 2 | cident iicide | Investig | not be | e. Place of I | | me, farm, stre | M eet, factory, | 1 🗆 Y | ∕es 2□ | - | 28f. Location (| | | er or Rural | Route Number, |
| hours affined in y filled in cal C | | ier 1 | Certifying | Physician: | To the best | of my knowl | edge, death c | occurred at t | he time, | date and | place, ar | nd due to the c | ause(s) | and manr | ner as stat | ed. |
| o the Hospita //ithin 24 hours o the Funeral ompletely filled | | k 2 L one) 3 L | _ Medical E | xaminer: Or | the basis o | f examination | and/or invest | death occur | y opinior | n, death od e time, dat | curred at | the time, date ce, and due to | and plathe cau | ce, and du | e to the car nanner as s | use(s) and manner stated. stated. |
| 15 | > | | 14 | 1 | M | 0 | | | 25 | 51 | 8 | 7 | | 1/2 | 3/ | 12 |
| 74 | | +1~ | le c | who complet | | | 23a) (Type, P | Ann | ٠ | A- | - 70 | 1 | led | 1100 | 1 | ente. |
| State Registrar | 31. Date file | | AN 27 | 2012 | 32, Vegis | trar's Signat | dreg. | ade | | | | | | | | |

| | | | State of Maryland / Dep | artment of Health and I | 2012 | 01.740 |
|---|---|----------------|---|--|---|---------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | rimodio or Bodin | Reg. No./ U / C | 3. Time of Death |
| | Physicia Medic | | George A. Simms | | January 30, 2012 | 6:15 P ^M |
| | Examin | | 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | |
| resident | | | Lorien Mount Airy | Mount Airy | Carrol1 | |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i>) 579−18−1357 1 XM 2 □ F 86 Yrs. | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | (Month, Day, Year) Coun | |
| | 34.0 | | 579−18−1357 1 XM 2 □ F 86 Yrs. Usual Residence of Decedent | | March 2, 1925 Wash | ington, D.C. |
| bus | shov | tor | 10a. State 10b. County 10c. City, Town or Lo | ocation | 1 | 0d. Inside City Limits |
| Man | 28a-f otifie | Director | Maryland Carroll Mount | Airy | | 1 X Yes 2 ☐ No |
| + 4 | Sa or | al D | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Cour | itry? |
| th with | ms 2; must | Funeral | 713 Midway Avenue - Apt 322 | 21771 | U.S.A. | |
| ر ا د م | or ite | by Fu | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1. \(\bar{Y}\) yes 2 □ No | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- Rican, etc.) 14. Race - Americ Black, White, | |
| 21213-UUSD within 72 hours after | ral", (Exan | q pa | | 1 ☐ Yes 2 ☐XNo Specify: | Specify: Whi | te |
| ח-ה | 'natu dical | Completed | 15. Decedent's Education 16a. Dece | dent's Usual Occupation kind of work done during most of work | 16b. Kind of Business/Ind | dustry |
| 7 | han 'e Me | om | Elementary/Secondary (0-12) College (1-4 or 5+) life. E | OO NOT use retired) | U.S. Govern | |
| | ther th | Be C | 12 17. Father's Name (First, Middle, Last) | rinter | Printing Of | fice |
| yland Id be filed | n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at | 70 E | George A. Simms, Sr. | | ne (First, Middle, Maiden Surname) nknown | |
| | mari mati | | | | al Route Number, City or Town, State, Zip C | 21771 |
| Man 1 | alth a 27 is r trau | Ì | | | ourt, Mount Airy, M | 1 |
| e je | of Her Fitem | | 20a. Method of Disposition 20b. Place of Disposition | | Date 20c. Location - City or To | |
| | ant: I | | 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State cemetery, creduction 4 ☐ Donation 5 ☐ Other (Specify) | tan Crematorium 2 | /1/12 Alexandria, | Virginia |
| parmit Page 1 and | Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. | | 21. Signature of Fun ral Service Signsee Orbort L. Nilliams 2 | 2 Name and Address of Eacility Molesworth-Willia 26401 Ridge Road, | ms P.A., Funeral Ho Damascus, Marvlan | me d 20872 |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. | er the mode of dying, such as cardiac | or respiratory arrest, | Approximate Interval Between |
| | sician/ | | Immediate Cause (Final disease or condition Failure to Thriv | e | | Onset and Death |
| | Medical xaminer | | resulting in death) Due to (or as a consequence of): | | | |
| | | er | Sequentially list conditions, if any, leading to immediate b. Peripheral Edema Due to (or as a consequence of): | | | Years |
| pel | nsit | mi | Cause (Disease or injury Hypertension | | | Years |
| xecu | n and ial-tra | Exa | that initiated events resulting in death) Last C. Due to (or as a consequence of): | | | icars |
| e be c | been signed by the attending physician and should be detached for use as the burial-transit | dical Examiner | d | | | |
| OO/O | ng ph | Mec | IF FEMALE: | | | |
| th cer | itendi or use | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 | | 23d. Date of deliver | · |
| e death c | the at | ysic | 1 Yes 2 No 4 Pregnant at time of death 5 Unknown 9 Unknown | Other (specify) | ivionin | Day Year |
| at the | ad by detac | | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I. | 23e. Did tobacco use contribute to th | e cause of death? |
| ires t | n sign | Completed by | Hyperlipidemia, Acid Reflux | | 1 ☐ Yes 2 🔀 No 3 ☐ Prob | pably 4 Unknown |
| e law requires | s beer | Slete | Depression | | | sy findings available |
| he lay | te has | E O | | | performed? death? | npletion of cause of |
| VILGIT F | ctor, p | | 25. Was case referred to medical examiner? | 26. Place of Death (Chec | | 2 110 |
| VII. | his ce al dire | 욘 | 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatie | nt 3 DOA Other: 4 🕅 Nursing Ho | ome 5 Residence 6 Other (Specify) | |
| ing P | After ti funera | ate: | 27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of injury 28b. Time o injury injury | work? | 28d. Describe how injury occurred | |
| Attendi | death stor: / y the | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be A Deposition determined 28e. Place of Injury - At home, farm, str | M 1 Yes 2 No | OOL Laarling (Ourseless of Abrahaman David | D. J. M. W. |
| lorA | after Direct | | 4 Homicide determined 20e. Place of Injury - At norme, sami, su building, etc. (Specify) | eet, ractory, office | 28f. Location (Street and Number or Rural City or Town, State) | Houte Number, |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed | within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical | 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death | | | |
| ne Ho | in 24 l ne Fu pletel | Med | (Check 2 Medical Examiner: On the basis of examination and/or invest only one) 3 Certifying Nurse Practitioner: To the best of my knowledge | | | |
| 10 ₩ | 문 ᆓ E | | 29b. Signature and tithoof certifier | 29c. License number | 29d. Date signed (Month, D | |
| | ₹68 | | /** | Hoo70147 | January 31 | |
| | | | Wey hourson | 10070147 | January 31 | , 2012 |
| | | | 30. Name and address of serson the completed cause of death (Item 23a) (Type, | Print) | | , 2012 |
| | Par | | Nilay Thaker 1502 South Main S | Print) treet, Mount Airy | | , 2012 |
| | | | Nilay Thaker 1502 South Main S | Print) | | , 2012 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) agdha012 **Physician** anuary Frances Louise Sines /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hagerstown Washi Lutheran avenwood Village 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplac 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Min Hours 1 □ M 2 🕅 F Maryland Oct. 11 Director 215-36-6460 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show! 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, the "nedical Exprained in injury or other traumatic event, the "nedical Exprained in injury or other traumatic event, the "nedical Exprained in its property." 1√Yes 2 No Director MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number with U.S.A. 21740 1183 Luther Drive Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2XNo Specify Specify: White ş 3 ☐ Widowed 4 ☐ Divorced Department of Health and Mental Hygiene, important: If item 27 is marked other than "natural", any injury or other traumatic event, The Medical Expany injury or other traumatic event, The Medical Expany injury or other traumatic event, The Medical Expany Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Charlotte Rhoderick Thomas Franklin Thompson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5703 Mountain Laurel Place, Frederick, MD Kenneth K. Sines / Husband Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Grdns 01/31/12 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 22. Name and Address of Facility Robert E. Dailey & Son Funeral Homes, 1201 North Market St., Frederick, MD 21. Signature of Funer Se Ratt E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Due to (or as a consequence of): Immediate Cause (Final **Physician** 54cas enin disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerty of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 242 No 1 ☐ Yes 2 No 1 ☐Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 12 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending PhysIclan; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> 31. Date filed (Month, Day, State Registrar

Medical

Year)

29a. Certifier

(Check only

29b. Signature and title of certifier

36 P 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

| nthony Vernon | | State of Maryland / Department of He | | | 201 | 2 0474 |
|---|---------------|--|--|---------------------|---------------------------------------|--|
| Physician | n/ | Registrar 1. Decedent's Name (First, Middle,Last) | | 2. Date of Dea | eg. No. th Day Year | 3. Time of Death |
| Medical Examina | er | Anthony Vernon 4a. Facility Name (if not institution, give street and number) 4b. Ci | ity, Town, or Location of Dea | February 5 | 5, 2012 4c. County of Deat | 0001 hrs |
| | | | nnapolis | .11 | Anne Arunde | |
| Funeral Director | | | Under 1 Year If Under 24H onths Days Hours Mi | | th(MM/DD/YYYY) 9. Bi)/1962 Forei | orthplace (State or gen Washington, buntry) D.C. |
| any | Ī | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | | 10d. Inside City Limits |
| | Ĕ | Florida Broward Coral Spri | ings | | | 1 X Yes 2 No |
| Maryland 28a-f show | ~ L | 10e. Street and Number 10f. | . Zip Code | 1 | Og. Citizen of What Cou | intry? |
| death with the Maryland ritems 23a or 28a-f sho gust be notified at once. | _ | 2060 Augusta Terrace | 33065 | | USA | dan la dina Olashi |
| eath w | unera | 1 Never Married 2 X Married Armed Forces? If Yes, sp | cedent of Hispanic Origin? (s pecify Cuban, Mexican, Puerl | | White, etc. | rican Indian, Black, |
| after after iner a | ð F | 3 Widowed 4 Divorced of Divorced or Dates: | 2 X No specify: | | | ite |
| hours | | | sual Occupation (Give kind or f working life, DO NOT use re | | 16b. Kind of Business | 'Industry |
| 036 thin 72 ne. | Completed | 12th Owner | | | Marketing/ | Travel |
| | | 17. Father's Name (First, Middle, Lest) Thomas L. Vernon | | | Maiden Surname) | |
| 212, and be Mental marke | o Be | | ress (Street and Number or | | Boccabello nber, City or Town, State | |
| MD d 2 sho lith and n 27 is | | | verton Place, | | | |
| Baltimore, MI permit. Pages I and 2 s Department of Heath a Important: If item 27 injury or other traum. | | 20a. Method of Disposition 1 | ace) | Date | 20c, Location - City or | |
| Baltimore, permit. Pages I at Department of Hee Important: If ite Injury or other tr | | 4 Donation 5 Other Specify: Resurrection 21. Signalure of Funeral Service Incensee 22. Name : | n Cemetery 2, and Address of Facility G | /10/12 | Clinton, | |
| Depa Depa Impo injur | | | 3 Solomons Is | | | |
| Physician | 7 | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo failure. List only one cause on each line. | ode of dying, such as cardiac | or respiratory arre | est, shock, or heart | Approximate Interval Between Onset and |
| /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) a. Narcotic Intoxication Due to (or as a consequence of): | | | | Death |
| | | Sequentially list conditions, b | | | | |
| | jue | if any, leading to immediate cause. Enter Underlying Cause Close Cause C. Due to (or as a consequence of): C. | | | | |
| d ansit | Examiner | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | |
| be executed sician and unial - transi | Gica | □ AMENDED 23a,27,28a-f,per | me, g924 2-22- | -12 sm | | |
| | ŝi | IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 2 Fetal december 2. | eath 3 Ectopic pregr | 2004 | 23d. Date of deliver | y Day Year |
| Box 68760 e death certificate be the attending physical for use as the bu | iciar | past 12 months? 4 Pregnant at time of death 5 Other (3) | | | MOHE | Day fear |
| 00 g gg 2 | Physicia | 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underly | ving cause given in Part I | 23e Did to | bacco use contribute to | the cause of death? |
| ires that the signed by signed by I be detach | [출 | Sommer and a second of the sec | ying oddoo givon iir i dat i. | | 2 No 3 Pro | |
| of Vital Records, as Physician: The law requir ufter this certificate has been sonal director, page 2 should | Completed | | | 24a. Was a | | utopsy findings available completion of cause of |
| Reco The law cate has | E O | | | perfor 1 Yes | | es 2 No |
| Vital Recypician: The list certificate lidirector, page | 8 | 25. Was case referred to medical examiner? Hospital: 4 Innation 2 FR/Outnation 3 | 26.Place of Death (Check | | Residence 6 🗸 Othe | |
| n of VI | 의 | 1 ✓ Yes 2 No Particular 2 Live Superior 27. Manner of Death 28a. Date of Injury 28b. Time of Injury | DDA Nurs 28c. Injury at Work? | | now injury occurred | r: Scene |
| ion tendin for: A the fur | ation | 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation fd 2-5-12 fd 11:25 p | 1 Yes 2 X No | unknown | 1 | |
| Division ratendin rate of the | Certification | 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, fact | | or Town, S | Street and Number or Rutate)2052 Quak | ural Route Number, City |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | | 4 Homicide (Specify) Found: Residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at | | Annapo | lis,Md. | |
| romplet | edical | one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated. | | | | |
| | ž | | 29c. License number | | 29d. Date signed (Mo | |
| | | 30. Name and address of person who completed cause of death (Item 23a) | O.C.M.E. | | 1 eviuary 5, 2012 | |
| H(0. | | Ling Li, MD Assistant Medical Examiner 900 W. Baltimore St | treet, Baltimore, MD 2 | 1223 | | |
| Stat Registra | - | 31. Date filed (Month, Day, Year) FEB 0 8 2012 | Les . | | | |
| | | | | | | |

WPJ6HT, CHPLISTINE

| | | | For State of Maryla | | | | | 20 | 12 | 01.71.3 |
|--------------|--|------------------|--|--|--|--------------------------------|--|--------------------------|-----------------------------------|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | Cert | tificate of D | eairi | 2. Date of Deat | eg. No./ U | 16 | 3. Time of Death |
| | Physicia Medic | | CHRISTINE KAY WRIGHT | | | | Month | y 3/ 2 | Year | |
| 0 | Examir | er | 4a. Facility Name (if not institution, give street and number) SHADY GROVE HOSPITAL | | 4b. City, Town, or ROCKVI | | 4 | 4c. County MONT | | RY |
| | Funeral | | | . last birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | 1 | | lace (State or Foreign |
| | Director | | 284-64-0431 1 □ M 2 ☑F 54 Usual Residence of Decedent | Yrs. | | | 11/10/ | | | Ή |
| | yland -f show ed at | ctor | | City, Town or Loc | | | | | 10 | 0d. Inside City Limits |
| | he Mar or 28a | Dire | MD FREDERICK 10e. Street and Number | FREDER | 10f. Zip Code | | 1 | 0g. Citizen of V | Vhat Count | 1 ▼ Yes 2 □ No trv? |
| | death with the Maryland items 23a or 28a-f sho ner must be notified at | Funeral Director | 1326 APPLETREE CT. | | 21703 | | | us | | |
| 215-0036 | s after ral", or Exami | ρ | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in L Armed Forces? 1 Yes, Give Year or Dates. | | /as Decedent of His Yes, specify Cubar | | cify Yes or No- Rican, etc.) | Blac | e - America k, White, e WHI | etc. |
| 15-0 | 72 hou n "natu fedical | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give ki | ent's Usual Occupa ind of work done do | | ng | 16b. Kind of Bu | usiness/Ind | lustry |
| 212 | led within 7. Hygiene. other than | Co | Elementary/Secondary (0-12) College (1-4 or 5+) | DEPAR | NOT use retired) TMENT M | ANAGER | | RE | TAIL | |
| and | 1 and 2 should be filed within 72 hour f Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical | To Be | 17. Father's Name (First, Middle, Last) DONALD RAY WRIGHT | | | 18. Mother's Name | | | | GT. |
| Maryland | should be fi and Mental is marked aumatic ev | 8 | 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing | g Address (Street a | | A LOUIS I Route Number, | | | |
| Baltimore, M | nd 2 st lealth a m 27 is ner tra | | CHRISTINA WRIGHT/DAUGHTER | | APPLET | | | | | |
| | permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other | | 1 Rurial 2 Cromation 2 Removal from State | Place of Dispos cemetery, crema NOCACY | sition (Name of attory or other place CEMETE | e) ! | 1 | 20c. Location - BEALL | • | |
| Balt | permit. Depart Import any inj | 10 | 21. Signature of Ferreral Service Licensee | | Name and Address | - | | O. BO | | |
| | Physician/ Medical | | 23a. Part 1. Enter the disease, or complications that caused the decisions, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conse | | _ | , such as cardiac c | r respiratory arre | st, | | Approximate Interval Between Onset and Death |
| 09, | executed physician and physician and sthe burial-transit | edical Examiner | Seque tidally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect of the condition of the consect of t | quence of): | E LEAK | OF COL | ON CO, | NTENT | 1 | |
| . Box 68760 | To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as | Ž | F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fe | etal death 3 | Ectopic pregnancy Other (specify) | , | | 23d. Dat Mo | te of delive | ery Day Year |
| ls, P.O. | iires that the signed by ald be deta | d by Ph | Part II. Other significant conditions contributing to death but not a Chrome DS: Wetwo pull | _ | derlying cause give | en in Part I. | | eacco use contr | ibute to the | e cause of death? |
| Records, | sician: The law requ certificate has beel lirector, page 2 shot | Complete | orlon cancer | | | | 24a. Was ar autops perforn 1 Yes 2 | y ned2 | Vere autoporior to condeath? | osy findings available impletion of cause of |
| Vital | ysician: The la is certificate ha director, page | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatiant 2 | ☐ ER/Outpatient | Other | ce of Death (Check | | a 🗆 au | (0 (1) | |
| of | ng Phys ter this ineral di | | 27. Manner of Death 28a. Date of injury | 28b. Time of injury | 28c. Injury work? | 4 Nursing Ho | me 5 \square Heside 28d. Describe ho | | | |
| Division | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certificate: | Natural 5 Pending (Month, Day, Year) Accident Investigation 3 Suicide 6 Could not be determined About 1 Pending (Month, Day, Year) 28e. Place of Injury - At the building, etc. (Special Country) | home, farm, stree | M 1 🗆 1 | /es 2 No | 28f. Location (Str City or Town | | er or Rural i | Route Number, |
| | he Hospit in 24 hour he Funera pletely filla | Medical | 29a. Certifier (Check only one) Certifying Physician: To the best of my known control of the properties of the properti | ion and/or investi | gation, in my opinior | n, death occurred at | the time, date and | d place, and due | to the cau | ise(s) and manner stated |
| • | To t. With Com | | 29b. Signature and title of certified Aller Surveyor Control of the certified of the cert | , | 29c. License | number 43 | 25 | 9d. Date signed | (Month, D | / 20/2 |
| _ | 3 | | 30. Name and address of person who completed cause of death (Ite AGAN & CHANAGE ISLL | m 23a) (Type, Pr | int) DY GREW | E RO R | XXVI | LE M | 0 2 | 0830 |
| | State | | 31. Date filed (Month, Day, Year) 32. Revistrar's Sign | ature | brokel | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04744 State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:45 P FEBRUARY 2012 GRETA JANE WALBERT Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT If Under 1 Year If Under 2 8. Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number 7. Age (In vrs. last birthday) Days Hours 1 M 2 XF 10/14/1936 Director 220-32-0406 75 MARYLAND Usual Residence of Deceden show 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No MD KENT CHESTERTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral UNITED STATES 203 RADCLIFFE DRIVE 21620 death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. and Mental Hygiene. is marked other than "natural", or i Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced WHITE Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) CHILD CARE PROVIDER CHILD CARE 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ JOSEPH GEORGE COX **EDNA ELIZABETH COVEY** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau WILLIAM WALBERT, JR. / HUSBAND 203 RADCLIFFE DRIVE CHESTERTOWN, MARYLAND 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 02/07/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 30 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ 5day5 disease or condition resulting in death) Medical as a consequence of Examiner a hears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events and tran Due to (or as a consequence of): resulting in death) Last physician a sthe burial-/Medical requires that the death certificate be P.O. Box 68760 attending ph IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown g Unknown r signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has the lirector, page 2 s autopsv perform death? 1 ☐ Yes 2 ☐ No Yes 2 Hospital or Attending Physician: Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital 2 1 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Funeral Director: After Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No death. Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours after City or Town, State) Medical 29a. Certifie 🖢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one within 7 29b. Signature and title of certific

Registrar DHMH 17 Rev 7/2009

State

ms

Woshing

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1655

mD

516

32. Registrar's Signature

Usan Ki

0017036

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 22 2012 January 10:50A Doris Adair Watson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fairfield Nursing&Rehabilitation Anne Arundel Crownsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min Director 577-30-0060 1 □ M 2 🗓 F 85 Nov. 1, 1926 Washington, DC Usual Residence of Deced ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Director 1 🗌 Yes 2 💢 No Rose Haven Maryland Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 7019 Boston Ave. 20714 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 1 and 2 should be filed within 72 hours aft of Health and Mental Hygiene. item 27 is marked other than "natural", other traumatic event, the Medical Exa Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Carson W. Adair Virginia Curtis 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st.
Department of Health an.
Important: If item 27 is n.
any injury or other. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald C. Watson/Son 7019 Boston Ave. Rose Haven, MD 20714 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem. 1/30/2012 Cheltenham, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signati of Funeral Service License 2973 Solomons Island Rd. Edgewater, MD 21037 alas 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ca Interval Between Onset and Death Immediate Cause (Final ₹Tıyəician/ disease or condition resulting in death) End Stage Alzheimers Dementia 11 yrs Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

Within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed 1 L Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signal and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 389 J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer H. Clark, M.D. 6934 Aviation Blvd. MD 21061 Suite B, Glen Burnie, 32. Reg strar's Signature State Registrar

| | | | State of Maryland / Depa | artment of Health and Menta | | |
|--------------------------------|---|------------------|--|---|---|-----------------------------|
| | | | . 101 | rtificate of Death | Reg. No. 2012 04 | 746 |
| | | | Decedent's Name (First, Middle, Last) | 2. Dat | e of Death 3. Tin | ne of Death |
| | Physicia /Medic | | Frances J. Wood | | uary 29 2012 7: | 50 A ^M |
| 3 | Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | |
| | | | Homewood at Crumland Farms 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | Frederick If Under 1 Year If Under 24 Hrs. 8, Dat | Frederick e of Birth 9. Birthplace (St | ate or Foreign |
| | Funeral Director | | 5. 30 all 3ecunity Number 1. Age (m.y.s. last billiology) 1 | Months Days Hours Min. (Mo | inth, Day, Year) Country) 12, 1922 North Can | - |
| | D D | | Usual Residence of Decedent | | | |
| | anylan show | _ | 10a. State 10b. County 10c. City, Town or Lo | cation | | de City Limits Yes 2∑ No |
| | ha Ma | Director | Maryland Frederick Frederi | | 10g. Citizen of What Country? | 100 22,110 |
| | with t | Dir | 10e. Street and Number | 10f. Zip Code | United State | 0.0 |
| | death | Funeral | 7400 Willow Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. | 21702 Was Decedent of Hispanic Origin? (Specify Ye f Yes, specify Cuban, Mexican, Puerto Rican, | | |
| 9 | or Ita | Fur | 1 Never Married 2 Married 1 Yes 2 No | If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify: | | |
| 8 | be filad within 72 hours after death with the Maryland ntal Hygiene. Id other then "naturel", or Items 23a or 28a-f show event, the Medical Exempter roust be multiped at event, | d by | 3 ₺ Widowed 4 Divorced Year or Dates: | | Specify: White | |
| 5-(| "natu | Completed | (Specify only highest grade completed) (Give | dent's Usual Occupation kind of work done during most of working DO NOT use retired) | 16b. Kind of Business/Industry | |
| 12 | withir ene. than | dwc | Elementary/Secondary (0-12) College (1-4or 5+) | ncher | Public Schoo | 1 |
| b | e filad within al Hygiene. i other than " vent, I'll Wel | Be C | 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, | Middle, Maiden Surname) | |
| ılar | should be nd Mental marked o | To B | Carl C. Jolley | Vera Madg | e Harrill | |
| Baltimore, Maryland 21215-0036 | 2 should and Men is marke eumatic | | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin | ng Address (Street and Number or Rural Route | Number, City or Town, State, Zip Code) | |
| 2, | ロモトラ | | | | k, Maryland 21701 | |
| Ö | permit. Pages 1 and Department of Heall Important: If Item 2 any injury or othar ance. | | 1 Burial 2 Cremation 3 Hemoval from State | natory or other place) January | 20c. Location - City or Town, Sta | |
| 틀 | permit. Pa Departmen Important: any injury | | | Crematory 30, 201 | | |
| Ba | permi Depa Impo any iu | | | 2. Name and Address of Facility Stauff 521 Opossumtown Pike | | |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. | <u> </u> | | |
| | Pnysician : | | Immediate Cause (Final disease or condition | elecatic Heart D | Unser | and Death |
| Ċ. | /Medical | | resulting in death) a Due to (o/ a. a.c. ns uence of): | 6 125/11/C JOH 17 | 15 crise | this |
| | Examiner | | Sequentially list conditions. | | 1 | |
| | sit ad | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | |
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| 687 | leath certificate t attending physi | | 0. | | | 1" |
| Вох | death certificat e attending phy id for use as th | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ | ⊒Ectopic pregnancy | 23d. Date of delivery | |
| O. B | deat he ath ed for | sicia | in the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ | Other (specify) | Month Day | Year |
| P.O. | that the ad by th detache | Phy | 9 □ Unknjown | | e. Did tobacco use contribute to the cause | a of doub? |
| Ś | w requires that the de been signad by the s should be detached | by | Part II. Other significant conditions contributing to death but not resulting in the u | nderrying cause given in Part I. | 1 Yes No 3 Probably | |
| Ö | requires been sign should be | Completed | - 17 By 1443105 | + | | |
| Rec | G 25 CA | mpl | Diphytes Malling | 14 px 11 | autopsy prior to completion performed? performed? | of cause of |
| Vital Record | in: Ti | e Co | 25. Was case referred to medical | 26. Place of Death (Chec | Yes 25No 1 Yes 2 No | |
| > | Physicien: r this certific ral director. | To B | examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatier | Others | ☐ Residence 6 ☐ Other (Specify) | |
| J Of | ng Ph ter th | | 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) | f 28c. Injury at 28d. De Work? | escribe how injury occurred | |
| Sio | Attending ir death. ector: After by the funer | catic | 2 Accident investigation | M 1 Yes 2 No | | |
| Division | l or Att after d Direct I in by | Certification; | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify) | | cation (Street and Number or Rural Route y or Town, State) | Number, |
| | Hospital or 24 hours afte Funeral Dir tely filled in I | | 29a. Certifier Certifying Physicien: To the best of my knowledge, deat | n occurred at the time, date and place, and du | e to the cause(s) and manner as stated | |
| | e Hospital | edical | (Check only 2 Medical Examiner: On the basis of examination and/or in one) | vestigation, in my opinion, death occurred at the | te time, date and place, and due to the car | J Se (s) |
| | To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Me | 29b. Signature and title of pertifier | 29c. License number | 29d. Date signed (Month, Day, Ye | ar) |
|) | , | | MANIN (Mine di) | MDD 16428 | 1/3/12 | |
| | 6 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, | Print) | 1-1/10 | |
| | 7 | | | St./ Frederick, Mary | land 21701 | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) 32. Redistrar's Signature FEB 0 1 2012 | parket | | |
| | | 7 | | | | |

04747 State of Maryland / Department of Health and Mental Hygiene | 2 Certificate of Death

| L | Physici | an | Decedent's Name (First, Middle, Las | | | | | 2. Date of De Month | Day | 3. Time of Death |
|------------|--|----------------|---|--|------------------------------|---|----------------------|---|--------------------|--|
| 8 | /Medic | | | Ruth Wood | | | | Januar | 7 | 012 8:50 P M |
| 4 | Examin | er | 4a. Facility Name (If not institution, give | | | 4b. City, Town, or | | Death | 4c. County o | |
| * | | | Sunrise Assisted 5. Social Security Number 6. Se | | ast histhday) | Frederi | LCK If Under 2 | 4 Hrs R Date of Bir | | erick 9. Birthplace (State or Foreign |
| | Funeral Director | | | 7. Age (iii yis. ii | - 1 | Months Days | Hours | Min. 8. Date of Bir (Month, Da Apr. 24 | 19, Year) | Country) California |
| 187 | | | Usual Residence of Decedent | 0. |) | | | Apr. 24 | 1920 | California |
| | land ow | | 10a. State 10b. County | 10c. City | r, Town or Lo | cation | | | | 10d. Inside City Limits |
| | Many -feh Lied | ţo | Maryland Frederi | ole | Fra | derick | | | | 1X Yes 2 No |
| | the | Directo | 10e. Street and Number | CK | 1160 | 10f. Zip Code | | | 10g. Citizen of Wh | nat Country? |
| | 3a o | | 990 Waterford Dr | iva | | 21702 |) | | United | States |
| | ms 2 | Funeral | 11. Marital Status | 12. Was Decedent Ever in U. | S. 13. V | | | in? (Specify Yes or No Puerto Rican, etc.) | | - American Indian, |
| ٥ | after or Ite | 3 | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give | | | | Puerto Rican, etc.) | | White, etc. White |
| 5 | ral', | 1 by | 3 ☑ Widowed 4 ☐ Divorced | Year or Dates: | | 1 105 22 NO | Specify: | | Specify: | MILTE |
| 9500-61212 | be filed within 72 hours after death with the Maryland als Hygiene. Als Hygiene. Als Hygiene "ratural", or items 23a or 28a-f ehow other then "natural", or items 23a or 28a-f ehow event, I're Medical Examinar must be notified at | Completed | 15. Decedent's Ed (Specify only highest grad | | 16a. Deced | ent's Usual Occupa kind of work done d OO NOT use retired | ation Juring most | of working | 16b. Kind of Bus | iness/Industry |
| 7 | of Ma | jd L | Elementary/Secondary (0-12) | College (1-4or 5+) | | | | · · | | |
| N | led w lygier her ti | S | 47.5.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4 | 3 | Regis | tered Nur | - | | Medica | |
| Maryland | tal H d ott | Be | 17. Father's Name (First, Middle, Last) | | | | 18. Mother | 's Name (First, Middle | , Maiden Sumame |) |
| <u>X</u> | outd Mer harke | 2 | Albert Joseph Sch | | 1 | | | orie Milva | | |
| <u>a</u> | 2 sh and is rr | | 19a. Informant's Name/Relationship (7 | | | | | or Rural Route Numb | | |
| ຕົ | es 1 and 2 should be filed w of Health and Mental Hygier If Item 27 is marked other tr ir other traumatic event, Ita | | | on and a | | Thooping (sition (Name of | Crane | Way New N | | aryland 21774 |
| 0 | ges tof the liftee or of | 7 | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ | | emetery, cren | natory or other place | э) I | ebruary | 20c. Location - C | ity or Town, State |
| Baitimore, | Pa tant: | | 4 Donation 5 Other (Specify | Sta | uffer | Crematory | 7 5 | , 2012 | Frederic | k, Maryland |
| žai | permit. Pages I Department of H Important: If Ite any injury or ot | | 21. Signature of Funeral Service Linen: | See | 22 | . Name and Addres | s of Facility | Stauffer | Funeral 1 | Homes, P.A. |
| | 707 = Q | - | KANA A | nho | | | _ | | | Maryland 21702 |
| | | | 23a. Part1. Enter the dis has r comp shock, or heart failure. List only of | one cause on each line. | | | | | rrest, | Approximate Interval Between Onset and Death |
| | Physician | | Immediate Cause (Final disease or condition | ESOPHA | 95 | AL | AN | CER | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a consequ | ience of): | | | | | |
| | Examiner | | Sequentially list conditions, | b | | | | | | |
| | be sit | ine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ | ience of): | | | | | |
| | and I-tran | Examiner | that initiated events resulting in death) Last | c Due to (or as a consequ | ience of\: | | | | | |
| Ď, | be e) cian buria | E | | 200 (0) 03 0 00/3040 | 101100 01). | | | | | Property |
| ğ | phys the | dic | | d | | | | | | |
| Box 68/60, | death certificate be executed e attending physician and d for use as the burial-transit | cian/Medicai | IF FEMALE: | 23c. If yes, outcome of pregnal | ncv | | | | 224 Date | at dalima. |
| o n | atten for u | ian | in the past 12 months? | 1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de | death 3 | Ectopic pregnancy Other (specify) | | | Mont | of delivery h Day Year |
| j | | Physic | 1 ☐ Yes 2 ☑No 9 ☐ Unknown | 9 Unknown | Julii 5 | Cirio (apaciny) | | | | |
| 7. | The law requires that the de ste has been signed by the a page 2 should be detached f | 4 | Part II. Other significant conditions co | ontributing to death but not resu | ilting in the ur | nderlying cause give | n in Part I. | 23e. Did t | obacco use contrib | oute to the cause of death? |
| S D | sign d be | d by | | | | | | 10 | Yes 2□No 3 | Probably 4 Kunknown |
| Hecords, | w requir been si should | Completed | | | | | | 24a. Was | 24 W | |
| ě | has ge 2 : | mp | | | | | | auto | psy pr | ere autopsy findings available or to completion of cause of ath? |
| | | | | | | | | 1 ☐ Yes | 2 No 1 | ☐Yes 2X No |
| VITAI | Physician: this certific ral director, | Be | 25. Was case referred to medical examiner? | Hospital: | | Othe | | of Death Check only | | Assisted |
| ō | Phys this rat di | 70 | 1 Yes 2 No 27. Manner of Death | 1 Inpatient 2 1 | ER/Outpatien 28b. Time of | 3D DOX | 4 Nur | | dence 6XOther | Assisted (Specify) Living |
| | ding After fune | ë | 1 X Natural 5 ☐ Pending | (Month, Day Year) | Injury | 28c. Injury Work | (? Yes 2 □ N | | now anjuly occurre | |
| DIVISION | Attending in death. ector: After by the fune | ical | 3 ☐ Suicide 6 ☐ Could not be | | me farm etr | | 163 2 11 | | Street and Number | or Rural Route Number, |
| <u> </u> | or Attendate death Director: | Certification: | 4 Homicide determined | building, etc. (Specify | ') | eet, factory, office | | City or To | | or noral noble Northber, |
| _ | pital ours oral filled | | 29a. Certifier 1X Certifying Phy | ysician: To the best of my know | uladga dagth | and the time | - data and | I sleep, and due to the | | |
| | To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer | edicai | (Check only 2 Medical Exam | iner: On the basis of examinat and manner stated. | ion and/or inv | estigation, in my op | oinion, death | n occurred at the time. | date and place, ar | ner as stated. ad due to the cause(s) |
| | ithin o the | Me | 29b. Signature and title of certifier | and marrier states. | | 29c. License | number | | 29d. Date signed | (Month, Day, Year) |
| ı | ⊢≯⊢ŏ | | 15/m2 | Tin | | | 795 | | _ | -2012 |
| | - 1 | | | omploted assess of death (** | 00a) (T | | | · · | | |
| | Q. | | 30 Name and address of person who o | 11, MD 814 | Toll F | tous Au | e. Fr | REDERICK | MD | 21701 |
| Sec. | Sta | te | 31. Date filed (Month, Day, Year) | 32. Ringistrar's Signal | enu | 36 | | | | |
| | Registr | 100 | FEB 0 1 20 | 12 anna | D. | arked | | | | |
| DH | MH 17 Rev 1/20 | 001 | | | 1 | | | | | |

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Peter L. Young 30 2012 6:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Colora Liberty Garden 8. Date of Birth (Month, Day, Year) 4 / 24 / 1932 Funeral 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Months Days 1 XM 2 □ F Country) Director Yrs. 182-24-3479 79 Usual Residence of Decedent Silvens and Mental Hygiene.

and Mental Hygiene.

f is marked other than "natural", or items 23a or 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No MD Ceci1 Colora 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Completed by Funeral 1670 Liberty Grove Road 21917 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 X Yes 2 No 1 ☐ Yes 2 X No Specify: 3 Divorced If Yes, Give Specify: White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Shopkeeper Small Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Lum Young Lucy Chan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Mark - nephew <u>4614 Roxbury Drive Bethesda.</u> MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/5/2012 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) T. Foard Funeral Home, PΑ Rising Sun, MD of uneral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, PA Oueen Street, Rising 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Priysician/ ovar disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autopsy death? After this certificate 2 \square No 2 N 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTAL LIVING 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 5 Pending 2 🗌 No Investigation Accident the 24 hours after deat Funeral Director; Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) Medica 29a. Certifier ✓ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month. Day. Year. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

∫ + VA State

Registrar

31. Date filed (Month

ORX

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jake Bob Adkins Merb. 8:44 рм 1^{Degy} 201^{ee}2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Carroll Westminster Funeral 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 🕅 M 2 🗆 F Days Hours March Day, Xear, 1925 Tennessee 415-32-3026 86 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Director 1 Yes 2 No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 Flower Ct. 21771 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Equipment Operator Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Manuel Adkins Alpha Pearl Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mem. Gardens Bertie Gates - daughter Mt. Airy, MD. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 22,2012 4 Donation 5 KD Other (Specify) tombment Fredericksburg, 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21, Signature of Funeral Service License Hank telleto 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line my Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine use as the burial-trans been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 Pregnant a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy After this certificate has perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural work? 5 Pending 2 🗆 No Accident Investigation Suicide
Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) H0061206 20 eted cause of death (Item 23a) (Type, Print oole Rd. Westminster 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

2

| | Please 1 - For State Registrar | | ryland / Dep | artment o | | and Mental Hy | ygiene Reg. No. 2 (| 12 04750 |
|---|--|--|--------------------------------------|----------------------------------|---------------------|---|-------------------------------|---|
| Physician /Medical Examiner | 1. Decement's Name (First, Middle, Las 4a. Facility Name (If not institution, give Johns Hopkins Bayvie | e street and number) | Contor | 4b. City, Tow | vn, or Location of | 2. Date of Death | death Day 4c. County | 3. Time of Death 2012 23 3 V |
| Funeral Director | 5. Social Security Number 6. S | | e (In yrs. last birthday) 73 Yrs. | If Under 1 Y | | 24 Hrs. 8. Date of B Min. (Month, D May 28 | Day, Year) | Birthplace (State or Foreign Country) MD |
| d 21215-0036 filled within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at a Completed by Funeral Director | 10a. State 10b. County MD Garrett 10e. Street and Number | | 10c. City, Town or L Oakland | 10f. Zip-Co | do | | 10g. Citizen of V | 10d. Inside City Limits 1 ☐ Yes 2% No |
| Ster death with ritems 23a or liner must be n | 165 Whistle Pic | 12. Was Decedent E Armed Forces? | ever in U.S. 13. | 21550 |) | igin? (Specify Yes or N n, Puerto Rican, etc.) | USA | ce - American Indian, |
| 215-0036 6. an "natural", or it Medical Examine | 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gra | 1 ☐ Yes ★★N If Yes, Give Year or Dates: ducation ade completed) | No 16a. Dece | 1 Tyes 2 Sedent's Usual C | No Specify: | | Specif | ^{fy.} White Business/Industry |
| d 21215-0(filed within 72 hou Hygiene. The Medical E ant, the Medical E Completed | Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) | College (1-4 or 5 | +) life. | ce Mana | etired) ager | er's Name (First, Midd | Grocery lle, Maiden Surnai | |
| re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Mar if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 s other traumatic event, the Medical Examiner must be notified. To Be Completed by Funeral Director | 19a. Informant's Name/Relationship (| | | | Street and Numb | ce Hurd | | |
| Baltimore, N permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to | Patricia Ann Ashl 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif | Removal from State | 20b. Place of Disp cemetery, cre | osition (Name matory or other | | Date Feb 24, | 20c. Location | - City or Town, State |
| Balti permit. Departri Importa any Inju | 21. Signature of Funeral Service Licen | MO | 1053 3 | 2. Name and A | | Donaldson Laurel, | Funeral | Home, P.A. |
| Physician /Medical | Mock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | a | e. Un will fa consequence of): | aus, | Mens | naites | 7 | Interval Between Onset and Death |
| 1760, ate be executed by the burial-transit and the burial-transit addrain Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | с | a consequence of): | | | | | |
| P.O. Box 6871 that the death certificate do by the attending physician/Medis | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown | 2 Fetal death 3 | ☐ Ectopic preg ☐ Other (speci | | | | ate of delivery onth Day Year |
| w requires that been signed by should be deticated by Poletted by | Part II. Other significant conditions of | contributing to death b | ut not resulting in the | underlying cau | use given in Par | | ŢYes 2 ☐ No | arribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available |
| Vital Record Iclan: The law require rector, page 2 should Be Completed | 25. Was case referred to medical examiner? | Hospital: | | | Other: | aut per 1 □ Yes e of Death (Check only | topsy formed? 22 No | prior to completion of cause of death? 1 ☐ Yes 2 ※ No |
| Division of Vital Records, P.O. Box 687(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medic | 27. Manner of Death 1 Natural 5 Pending investigatio 3 Suicide 6 Could not be determined | 28a. Date of Injur (Month, Day | y Year) 28b. Time Injury | of 28c | Injury at Work? | No 28f. Location | e how injury occu | |
| To the Hospital within 24 hours To the Funeral completely filled | 29a. Certifier (check only one) 29b. Signature and title of certifier | mysician: To the best of miner: On the basis of and manner sta | examination and/or | nvestigation, ir | n my opinion, de | | ne, date and place | ed (Month, Day, Year) |
| State | 30. Name and address of person who |). | r's Signature | | \$000 4 9 | 940 Eastern / | Avenue, B | altimore, MD, 2122 |
| Registrar | - LLD 0 1 | 2010 | | park | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death FEBRUARI ALMONG Physician/ J. orellA 18,2012 9:20 P.M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner SQUARE BALTIMORE FRANKLIN HOSPITAL KOSEDALE al Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** -4800 (Month, Day, Year) Months Hours Director West Virginia 28a-f show 10c. City, Town or Location 10b. County must be notified at Director 1 Yes 2 No MARYLAND 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number Funeral items 23a (1. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Ď, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: Specify: WHITE 3 ₩idowed 4 Divorced "natural" Completed injury or other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) RUNING PAIN RAF Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ be RUM Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is r.
any injury or externity CLARENCE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 22. Name and Address of Facility
W. DABRO SAIN
1005 Dun AM 21. Signature of Funeral Service Liee Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician/ disease or condition resulting in death) Medical Examiner OBSTRUCTIVE PULMONARY DISEASE HRONIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes Division of Vital Records, 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No page 2 s prior to completion of cause of death?

1 Yes 2 No has certificate or Attending Physician; director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this completely filled in hours. funeral 28c. Injury at work?
1 Yes 2 No 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifie 29c. Ligense number 30. Name and address of person who completed cause a death (Item 23a) (Type, Print) AUYEUN 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237 KAMKUN 31. Date filed (Month, Day, Year) State Registrar

Registrar
DHMH 17 Rev 06-201

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2012 Year Physician/ 1:24P 18 Charles William Albert Feb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 166 Willis St. Westminster 5. Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country. 220-26-5713 **1X** M 2 □ F 81 **Director** 12-18-1930 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits items 23a or 28a-f sho her must be notified at 10a. State 10c. City, Town or Location death with the Maryland Director Westminster MD Carroll 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 166 Willis St. 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner 1 X Yes 2 No If Yes, Give Year or Dates. 10 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Research Chemist Chemistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Dutterer William Albert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other trau 166 Willis St., Westminster, MD 21157 Suzanne Albert-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-21-12 Westminster, MD Kriders Cemetery | Signature Juneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home nomas Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final 3/6 avenus Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HOW 1100 W Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has je 2 autopsy page, death? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer work? injury Natural Accident 5 Pending Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 5 29c. License number 29d. Date signed (Month, Day, Year) DU C 20059943 20,2012 REDWAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) resumiser Asses Spurer MM 31. Date filed (Month 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George Thomas Benbow, III February 20, 2012 10:00P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Age (In yrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year) 213-44-0609 1 ▲M 2 □ F Director 66 Cheverly, MD. Yrs Feb. 14, 1946 Usual Residence of Decedent shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 XNo Cockeysville Maryland Baltimore County 10f. Zip Code 10g. Citizen of What Country? 1017-C 21030 United States Misty Lynn Circle death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 6 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural", 3 Widowed 4 XDivorced Completed th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12 04 Certified Internal Auditor Auditor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dolores Adele Piozet Robert Paul Benbow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 4 Beechmere Lane Cockeysville, Maryland 21030 Mrs.Polly Roberts (Sister) 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Evans Funeral Chapel and (Harford County) 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Donation 5 Other (Specify)

Cremation Services, Inc. Peb. 22, 2012 Forest Hill, Mary Latter of Funeral Service Licenses of Facility

Peaceful Alternatives Funeral and Cremation Center, P.A. rauz 1 Tic.#M00677 Timonium, Maryland 2325 York Road 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter chaoring Cause (Disease or injury Due to (or as a consequence of): as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown the detached 9 Unknown or Attending Physician: The law requires that the signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) Nospi 4 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred injury work? 1 Yes 2 No 1 Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical -Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and till 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAMES M AARON FEB 2 egistrar's Signature State

DHMH 17 Rev 06-2011

Registrar

| | | - | For State Of State Of Registrar | | rtificate of Deat | m and Mental Hy Th | Reg. No. 2 | 2 04.755 | | |
|------------|--|--------------|---|---|---|--|--|---|--|--|
| | Physicia | n/ | 1. Decedent's Name (First, Middle, Last) | Baker | | 2. Date of Do Month | Day Year | 3. Time of Death | | |
| | Medic Examin | al | Pauline E 4a. Facility Name (if not institution, give street and number) | Feb. | 18,2012 4c. County of Dea | 1 3:3UA | | | | |
| أعمدوه | Examin | er | Household of Angels | | Severna | | Anne A | | | |
| | Funeral | | 174 05 0005 | Age (In yrs. last birthday) | If Under 1 Year If Un Months Days Hou | nder 24 Hrs. 8. Date of Bi Irs Min. (Month, D | | rthplace (State or Foreign ountry) | | |
| | Director | | 174–05–0095 Usual Residence of Decedent | 101 Yrs. | | Oct | 6 1910 Ca | rlisle PA | | |
| | /land f shov ed at | tor | 10a. State 10b. County | 10c. City, Town or Lo | | | | 10d. Inside City Limits | | |
| | e Man r 28a- notifie | Director | Maryland Anne Arundel 10e. Street and Number | Pasade | na 10f. Zip Code | | 10g. Citizen of What C | 1 Yes 2 No | | |
| | 72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at | eral [| 152 Wileys Lane | | 21122 | | USA | ound y ? | | |
| | items | Funeral | 11. Marital Status 12. Was Decede Armed Force | ent Ever in U.S. 13. | Was Decedent of Hispanio | Origin? (Specify Yes or No kican, Puerto Rican, etc.) | 14. Race - Am | | | |
| 36 | al", or | d by | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Date | ¥ No | 1 ☐ Yes 2 🛣 No Spe | | | hite | | |
| 21215-0036 | hours "natur dical l | Completed | 15. Decedent's Education (Specify only highest grade completed) | 16a. Dece | dent's Usual Occupation kind of work done during | most of workina | 16b. Kind of Business | s/industry | | |
| 121 | within 72 giene. ner than t, the Me | Som | Elementary/Secondary (0-12) College (1-4 | or 5+) life. L | no NOT use retired) | | h | omemaker | | |
| | lled wit Hygiel other ent, th | Be | 17. Father's Name (First, Middle, Last) | 110 | | Nother's Name (First, Middle | 1-1- | Melignet | | |
| ylan | should be filed and Mental Hy is marked oth aumatic event | 10 | Ross | Franciscus | | Lena | Gi | reen | | |
| Maryland | ~ | | 19a. Informant's Name/Relationship (Type, Print) Barbara Way | | or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| | Heali Heali Item 2 | | 20a. Method of Disposition | 20b. Place of Disp | osition (Name of | Date Date | 20c. Location - City o | r Town, State | | |
| imo | nit. Page artment o ortant: If injury or | | 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from Si 4 ☐ Donation 5 ☐ Other (Specify) | late | matory or other place) er Cemeterv | Feb 21,2012 | Carlisle 1 | | | |
| Baltimore, | permit. Page 1 Department of Important: If i any injury or once. | | 21. Signature of Funeral Service Licensee | 1 2 | 2. Name and Address of F | Stalling Stalling | ngs Funeral | HOme P.A. | | |
| | | | 23a. Part 1. Enter the disease, or complications that car | used the death. Do not ent | 3111 Mountai er the mode of dying, suc | n Road Pasade h as cardiac or respiratory a | ena MD 2112: arrest, | Approximate | | |
| -25 | Physician/ | | shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition | REMAL E | Aller RE | | | Interval Between Onset and Death | | |
| | Medical Examiner | | resulting in death) a. Due to (or | as a consequence of): | 1/ = | T FAILUR | 842 | | | |
| | | Jer | Sequentially list conditions, if any, leading to immediate Due to (or | as a consequence on. | IVE HEAD | PAILUR | <i>E</i> | | | |
| | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events C. | ORONARI | 5/5 | | | | | |
| | cate be executed physician and s the burial-transit | al Ex | resulting in death) Last Due to (or | as a consequence oi). ORONA FM as a consequence of): AORTIC | GTEND | | | | | |
| 200 | cate be | edical | d | <i></i> | | | | | | |
| .89 | eath certifice attending p | | 23b. was decedent pregnant | ome of pregnancy | Ectopic pregnancy | | 23d. Date of d | elivery | | |
| Вох | t the death by the atte | Physician/N | | int at time of death 5 | Other (specify) | | Month | Day Year | | |
| P.O. | es that the igned by the be detacl | | Part II. Other significant conditions contributing to dea | th but not resulting in the | underlying cause given in | Part 1. 23e. Did | tobacco use contribute t | to the cause of death? | | |
| S, I | equires t sen sign rould be | ed by | OLD MYOCAI | a DIAL I | NFARCIT | ON 1 | Yes 2 No 3 | Probably 4 X Unknown | | |
| Records, | law requi has been ge 2 shoul | Completed | | | | | opsy prior to | utopsy findings available completion of cause of | | |
| Be | sician: The la certificate ha rector, page | | 25. Was case referred to medical | | 00 Bloom | 1 \(\sum \) Yes | formed? death? | es 2 No | | |
| of Vital | ysician: is certific director, | To Be | examiner? | patient 2 ER/Outpatie | Other: | Death (Check only one) Nursing Home 5 Res | sidence SC Other (Spe | ED LIVING | | |
| of | ng Phy fter thi uneral | | 27. Manner of Death 28a. Date of (Month) | | of 28c. Injury at work? | 28d. Describe | how injury occurred | | | |
| sion | ttendi death. stor: A y the fu | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be | f Injury - At home, farm, st | M 1 ☐ Yes | | (Street and Number or R | ural Route Number. | | |
| Division | al or A s after il Direct | Cer | 4 Homicide determined building | , etc. (Specify) | , | | own, State) | | | |
| | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic | Medical | 29a. Certifier (Check 2 Medical Examiner: On the basis | of examination and/or inve | stigation, in my opinion, dea | ath occurred at the time, date | and place, and due to the | e cause(s) and manner stated. | | |
| | ormple | M | only one) 3 Certifying Nurse Practitioners 29b. Signature and title of certifying | To the best of my knowledge | e, death occurred at the tim 29c. License num | e, date and place, and due to | the cause(s) and manner 29d. Date signed (Mon | as stated. | | |
| 9 | ->-0 | | 1 / Glente | X. | D271 | 57 | FABRUARY, | 19 2012 | | |
| | • | | 30. Name and address of person who completed cause | of death (Item 23a) (Type, | Print) | 70 4 0= | • | | | |
| | Sta | te. | R NYNOLD DEPESTRE 31. Date filed (Month Car Year) FEB 2 1 2012 32 Per | SIOD LORD | BALLIMORE | DR. FIJOI ION | ruitmone M | D ~1 ~44 | | |
| | Registr | | res 2 1 2012 | wa B. S | arke | | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Gladys Buts Physician/ 4:00 February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Seasons Hospice at Northwest Hospitall Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept 9, 1916 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Country) 212-03-3371 MD **Director** 1 □ M 🗶 □ F 95 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 X No MD Baltimore Randallstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3848 Elmcroft Road 21133 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) Clerical/School and Mental Hygien 10 Cashier/Crossing Guard Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Lemuel O. Robosson, Sr. Elizabeth Marie Fulkowski permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Sylvia Butts (Daughter) 3848 Elmcroft Road, Randallstown, MD 21133 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Wards Chapel Cemetery 2/21/2012 Randallstown, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licens 194 MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line End Stage Cardiomyopathy Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami nding physician and use as the burial-transit Cause (Disease or injury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law autopsy performed page 2 certificate Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 other (Specify) 2 🗹 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No n 24 hours after death.

The Funeral Director: After pletely filled in by the fur Certifical Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRy apahu M.D 00057465 2/16/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 203 21209 N.S. Rijapakse, M.D. Baltimore 2835 Smith AV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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21215-0036

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gene M. Billings 7:30p February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3601 A Green Spring Road Havre de Grace Harford If Under 1 8. Date of Birth (Month, Day, Year) 02/14/1916 Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** Davs Min **Director** 521-14-6421 1 □ M 2 96 Canada Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Director notified Maryland 1 🗆 Yes 2🔎 No Harford Havre de Grace ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 3601 A Green Spring Road 21078 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: White "natural" Completed 3₩idowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the in home 12 home maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is meany injury or other ပ Cecil E. Wiggins Julia E. Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta J. Wolff (daughter) 3601 A Green Spring Rd., Havre de Grace, MD 2178 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Company 2/21/2012 West Chester, PA 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Signature of Funeral Service Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phylician 2heiner disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ypothyroidism Records, 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed filled in by the funeral director, page 2 Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certific. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

To the I within 2 To the I

(Check

only one

29b. Signature and the of certifier

Aly Naguib

31. Date filed (Month, Day, Year FEB 2 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Colacte Dr. Forest Hill MD 21050

2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0059387

29d. Date signed (Month, Day, Year)

2/20/2012

12-01377 Christina Brown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 04758

| | | - For State Certificate O | f Death | Reg. No. | |
|---|----------------|--|---------------------------------------|--|--|
| Physicia | | Registrar 1. Decedent's Name (First, Middle,Last) | | 2. Date of Death | 3. Time of Death |
| ∵∹'cal Exami | | Christina M. Brown | | Month Day Year February 15, 2012 | 1722 hrs |
| | | 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | i i |
| | | 1907 Merritt Boulevard | Dundalk | Baltimore Cou | unty |
| Euparal | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | If Under 1 Year If Under 24Hrs | s. 8. Date of Birth (MM/DD/YYYY) 9. Bir | thplace (State or |
| Funeral Director | - 1 | | Months Days Hours Min | 8 -10 -1973 Foreign | gn ountry) / /// \ |
| Birector | L | 220-17-2379 1 M 2 F 38 YR | 3. | 0-10-1113 | 11(1) |
| , bo | | Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Loca | tion | | 10d. Inside City Limits |
| w any | | Toa. State | | | 1 Yes 2 No |
| and sho | 5 | MA Baltmore Hyde | 5 | Language of Mines Court | |
| Maryland 28a-f show d at once. | Director | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Cou | ritryr |
| the N | | 13430 Bottom Road | 21082 | USA | |
| 0036 within 72 hours after death with the Maryland jet ene "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once. | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. 13. W. | as Decedent of Hispanic Origin? (S | pecify Yes or No- Rican, etc.) 14. Race - Amer White, etc. | rican Indian, Black, |
| iten | 릭 | 1 Never Married 2 Married Armed Forces? | Yes, specify Cuban, Mexican, Puerto | Trinto, ste. | / / |
| | | 3 Widowed 4 Divorced If Yes, Give Yeer 1 | Yes 2 No specify: | Specify: W | ite |
| urs ad tural | ğ | | nt's Usual Occupation (Give kind of | | /industry |
| 2 hou | 뾽 | Elementary/Secondary (0-12) College (1-4 or 5+) | nost of working life. DO NOT use ref | (lired) | . / / |
| Hin 7 | 희 | 12 2 + | Disabled | Disal | 1/ed |
| d with | Completed | 17. Father's Name (First, Middle, Last) | 18.Mother's Nam | e (First, Middle, Maiden Surname) | |
| 11215-0036 Antal Filed within 72 hours after felled Within 42 hours after anarked other than "natural", event, the Medical Examinet. | B B | Tose Al Al BONDIN | No | rma L. Brow |) N |
| 21215-0036 Muld be filed within 72 hours after the marked other than "natural", cevent, the Medical Examiner. | | 19a. Informant's Name/Relationship (Type, Print) | ng Address (Street and Number or | Rural Route Number, City or Town, State | e, Zip Code) |
| S 2 2 3 2 | | -Tosehh N BOWN-Father 134 | 30 Bottom | Rd. Hydes, 1 | nD2/082 |
| e, ME and 2 sl Health au item 27 | | 20a. Method of Disposition 20b. Place of Dispo | sition (Name of cemetery, | Date 20c. Location - City o | r Town, State |
| Ore ges 1 of H | | 1 Burial 2 Cremation 3 Removal from State crematory or o | (Iner place) | 1,7/2 B- 11 | or x |
| Pag ment tant | | 4 Donation 5 Other Specify: Bayview | Name and Address of acility | 117/20/2 Da / 11/11 | Re //K/) |
| Baltimore bernit. Pages 1 a Department of H Important: If it | | 21. Signature of Funeral Service Licensee 22. | Name and Address or admity | ruley - ASKtON | FUNERAL d & 1222 |
| E E C E | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter | the mode of duing such as cardiac | or respiratory arrest shock, or the rt | Approximate Interval |
| Physician | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. | the mode of dying, such as cardiac | or respiratory arrest, orrest, or mant | Between Onset and Death |
| /Medical ≟xaminer | | Immediate Cause (Final disease a Dilated Cardiomegaly | | | Deau |
| LAdiiiiiei | | or condition resulting in death) Due to (or as a consequence of): | | | 11 |
| | | Sequentially list conditions, b. | | | |
| | ine | if any, leading to immediate Due to (or as a consequence of): | | | |
| | aminer | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | |
| uted Id ransit | Ä | d. | | | |
| executed ian and | Medical | ▼ UNPENDED | per me,g926 4-12 | -12 sm | İ |
| 60, ate be ex hysician to burial | 9 | IF FEMALE: 23c. If yes, outcome of pregnancy | | 23d. Date of delive | ry |
| 87 tifica ing pl as the | 2 | 23b. Was decedent pregnant in the 1 Live birth 2 F | etal death 3 Ectopic pregr | nancy Month | Day Year |
| Box 687(c death certifica the attending pl ed for use as the | Physician/ | 4 Pregnant at time of death 5 | Other (Specify) | | |
| BO e dear the at ed for | Ş | | | 23e. Did tobacco use contribute t | o the course of death? |
| d by | | Part II. Other significant conditions contributing to death but not resulting in the | | 1 Yes 2 ✓ No 3 Pro | |
| P.O. ires that to signed by | d by | Clinical history of chronic obstruc | tive pulmonary | | Silver Street Street |
| ords, w requir s been s should | Completed | Disease | | 24a. Was an 24b. Were a autopsy prior to | autopsy findings available 1 completion of cause of |
| CO law has e 2 sh | 립 | Discuse | | performed? death? | |
| tal Recision: The certificate | 🛭 | | 26 Place of Death (Chec | | |
| Vital Rec ysician: The l his certificate director, page | a | 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatie | | sing Home 5 Residence 6 Oth | er: Scene |
| Physic rethis | 유 | 1 Yes 2 No | | 28d. Describe how injury occurred | |
| JOF Ving Pb. | 岌 | (Month, Day, Year) | 1 Yes 2 No | , , | |
| ttenc death ctor: | ğ | 2 Accident Investigation | | 28f. Location (Street and Number or F | Rural Route Number City |
| Division of Vital Records, tal or Attending Physician: The law require as after death. Director: After this certificate has been sided in by the funeral director, page 2 should b | Certification: | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str | eet, factory, office building, etc. | or Town, State) | tarar (cate realizer) etty |
| Ours ours filled | 8 | 4 Homicide determined (Specify) | Plaza. | <u> </u> | |
| 24 h Frur etely | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investig | curred at the time, date and place, a | nd due to the cause(s) and manner as st that the time, date and place, and due to | ated. the cause(s) |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicial rot the death of the funeral director, page 2 should be detached for use as the burit | Medical | and manner stated. | | 29d. Date signed (N | |
| | Ž | 29b. Signature and title of certifier | 29c. License number | | |
| | | N-~UL - | O.C.M.E. | February 16, 20 | J12 |
| | | 30. Name and address of person who completed cause of death (Item 23a) | | | |
| | | Donna M. Vincenti, MD Assistant Medical Examiner 90 | 0 W. Baltimore Street, Balt | timore, MD 21223 | |
| 5 | tate | 31. Date for 18/19/19/19/12 32. Registrar's Signature | | | |
| Pogis | | · · · · · · · · · · · · · · · · · · · | | | |

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 18 per fb. 9925 3-1-12 sm State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:20P ebruar 15,2012 CLIFTON LUCULUS BROWN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM, MD If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Min 577-20-3789 Usual Residence of Decede **Director** 1 XM 2 F 90 MAY 11, 1921 VIRGINIA 28a-f show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD MITCHELLVILLE PRINCE GEORGES 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10450 LOTTSFORD ROAD APARTMENT 245 20721 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give 9 18 4425 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, artment of Health and Mental Hygiene.
ortant; If item 27 is marked other than "natural", or iter
injury or other traumatic event, the Medical Examiner. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) TELEPHONE Elementary/Secondary (0-12) College (1-4 or 5+) TELEPHONE REPAIR MAN 12 COMMUNICATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ VIRGINIA WARREN BROWN Edwards JOSEPH SIDNEY BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau MARCIA VAUGHN - DAUGHTER 9392 STONESTREET ROAD, LA PLATA MD 20646 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) POTOMAC CREMATORY 2-24-2012 DALE CITY, VIRGINIA 22. Name and Address of Facilit CUNNINGHAM FUNERAL HOME 811 CAMERON ST. ALEXANDRIA w 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) s a consequence of) Due to (o Examiner neumonia Sequentially list conditions, if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): attending physician If for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 No this certificate 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific. Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work?
1 \sum Yes 2 \sum No 2 Accident
3 Suicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar DHMH 17 Rev 06-2011

State

101

29b. Signature മറിd title of certifier

MO

8118

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Beyeve

29c. License number

D0068976

29d. Date signed (Month, Day, Year)

Luck Road, LANHAM, MD 2070 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month B BOPP 420 PM 2012 OZ4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CITY 1405 PITTAL SAMARITAN BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗷 F Days 91 Min Hours (Month, Day Year) 187-16-2300 1920 Pennsylvania Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1-X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2206 Lake Avenue 21213 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc.

Baltimore, Box 68760 P.O. Division of Vital Records,

1 - For State Registrar

10a. State

INDA

Physician/

Medical

Examiner

Funeral

Director

show

28a-f

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21215-0036

Maryland

notified at

Director

Funeral

| Jam | | | Please | Type or Print in I AMEND TTEM#1 State of Marylan | Black Indelik Og per FH , G id / Departmei | ole Ink. Ensure 1924, 2/21/2012 nt of Health and I | All Copies A WS Mental Hygie | Are Legible. ene | | | | |
|----------|---|-------------------|---|---|--|---|---------------------------------------|--|--|--|--|--|
| 3 | | | For State Registrar | | | te of Death | | . No. 2012 | 04761 | | | |
| 2 | Physicia Medic | | 1. Decedent's Name (First, Middle, Lass | lotte Bak | sh-Mck | lenzie | 2. Date of Death | ¹ 16, aŏ12 | 3. Time of Death | | | |
| 16-12 | Examin | er | 4a. Facility Name (if not institution give 9006 Blue Too | 01 | 4b. Aity | olumbia | | 4c. County of Death | rd | | | |
| 2-1 | Funeral Director | | 5. Social Security Number 217-53-8470 Usual Residence of Decedent | 7. Age (In yrs. II | ast birthday) If Under Months Yrs. | | 8. Date of Birth (Month, Day, Ye) | ear)Cou | hplace (State or Foreign intry) gland | | | |
| Ū, | faryland 8a-f show irfied at | Director | 10a. State 10b. County House | Λ / | y, Town or Location | C | | | 10d. Inside City Limits 1 Yes 2 No | | | |
| enzi | with the Maryland s 23a or 28a-f sho ust be notified at | Funeral Di | 10e. Street and Number Po | ol | 10f. Zi | a1045 | 100 | g. Citizen of What Co | untry? United Kingdom | | | |
| とられ | ind 21215-0036 filed within 72 hours after death with the Maryland tal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. | led Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Blac Yes 2 IV No Specify: Specify: Specify: | | | | | | | |
| te 1 | 21215-C within 72 hou giene. | Completed | 15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) | ducation ide completed) College (1-4 or 5+) | life. DO NOT us | ork done during most of wor | rking | Sb. Kind of Business/ | . 1 | | | |
| 0 - | Iryland 2 Juld be filed w Mental Hygi marked other matic event, i | To Be | 17. Father's Name (First, Middle-Legt) | Ksh | 1.10000 | 18 Mother's Na | me (First, Middle, Mai | | te | | | |
| 785 | Mar 12 shou lith and 27 is m | | 19ay Informant's Nama/Relationship (7) | pa Print) (Husband Kenzie | 19b, Mailing Address | ss (Street and Number or Ru | | | 21045 | | | |
| <i>ن</i> | A . O - 1 | | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif | Removal from State | Place of Disposition (M Pennen Carrie Disc) | ame of (ther place) | Date 20 | oc. Location - City or | Town, State FL | | | |
| sula | Baltimo | | 21. SigNature of Funeral Service Licens | | 22. Vet | and Afgress of Cility Co | reene F | general & | Services | | | |
| Jr Se | | | 23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final | olications that caused the dear | | de of dying, such as cardiac | or respiratory arrest | ., | Approximate Interval Between Onset and Death | | | |
| ٦ | Medical Examiner | | disease or condition resulting in death) | a. Due to (or as a conseq | | st Cancer | | | 3 years | | | |
| | ed nsit | Examiner | Sequentially list conditions, if any, leading to immediate outce. Entar Unioning Cause (Disease or injury | b. Due to (or as a conseq | quence of): | | | | | | | |
| | be executed sician and burial-transit | _ | that initiated events resulting in death) Last | Due to (or as a conseq | quence of): | | | | | | | |
| | Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be ex 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician relay filled in by the funeral director, page 2 should be detached for use as the burial area. | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown | 23c. If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of g Unknown | tal death 3 🗌 Ectopi | | | 23d. Date of de Month | elivery Day Year | | | |
| | P.O. | 2 | Part II. Other significant conditions of | ontributing to death but not re | sulting in the underlying | g cause given in Part I. | | | o the cause of death? | | | |
| | cords faw require has been s le 2 should | Completed | | | | | 24a. Was an autopsy | 24b. Were au prior to death? | utopsy findings available completion of cause of | | | |
| | fital Reco sician: The law a certificate has b lirector, page 2 s | ပ္ပြ | 25. Was case referred to medical | 74. | <u> </u> | 26. Place of Death (Che | 1 🗆 Yes 2 | No 1 ☐ Ye | s 2 No | | | |
| | Vital ysician: is certific director, | To Be | examiner? 1 Yes 2 No | Hospital: 1 ☐ Inpatient 2 ☐ | ☐ ER/Outpatient 3 ☐ | To: | | nce 6 Other (Spe | cify) | | | |
| | n of V ing Phys after this | | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of injury (Month, Day, Year) | 28b. Time of injury | 28c. Injury at work? | 28d. Describe how | v injury occurred | | | | |
| | Division of Vital Records, P.O. to the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by a completely filled in by the funeral director, page 2 should be detacled. | Certificate: | 2 Accident Investigatio 3 Sulcide 6 Could not b 4 Homicide determined | | M nome, farm, street, factory) | | 28f. Location (Stree City or Town, | eet and Number or Ru State) | ural Route Number, | | | |
| | Hospital 4 hours 7-uneral tely fillec | Medical | (Charle 2 Medical Evam | sician: To the best of my know iner: On the basis of examination | on and/or investigation | in my opinion, death occurred | at the time, date and | l place, and due to the | cause(s) and manner stateu. | | | |
| | To the F within 24 To the F complet | ₩ | only one) 3 Certifying Nur 29b. Signature and title of certifier | se Practitioner: To the best of | my knowledge, death o | occurred at the time, date and 9c. License number | place, and due to the | cause(s) and manner Id. Date signed (Moni | as stated. | | | |
| | FSFÖ | | > Loing R | Sarbano | | D0071600 | | 02/16/2 | 2012 | | | |
| | A 44 | | 30. Name and address of person who Tejasw: R. Sastry | | m 23a) (Type, Print) Charter Dr. | Ct. Gozo | Columbia | a, mb 21 | 044 | | | |
| | | | | | | MIN PULL | | | , | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25tate of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 21 Decedent's Name (First, Middle, Last, 2. Date of Death Month Physician/ Unknown M 191ne Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. Gounty of Death Examiner Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth If Under 24 Hrs. **Funeral** Min (Month, Day, Year) 219-40-3618 **Director** 1 M 2 V 66 Yrs. 5-23-1945 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Medical Examiner must be notified 1 Yes 2 No ds Howard 9 10e. Street and Numbe 10g. Citizen of What Country? Funeral items 23a death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. or þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than fe. DO NOT Elementary/Secondary (0-12) College (1-4 or 5+) the Be 17. Father's Name (First, Middle, Last, permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ reeman 059 ampson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 02/02/2012 1 Burial 2 Cremation 3 Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility Greene Funeral Kandall stown MD21133 23a. Part 1. Entey the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or have failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final brain asses set and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi and Due to (or as a consequence attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the at id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Records, 1 Yes 2 No 3 Probably 4 Hiknown Completed plnods been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗌 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gartifying Nurse Practitioner: To the best of my thouledge, death on 29b. Signature 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 1, 12 ASHAR

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

#32: Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:31PN SHIRLEY ANN SARNES 02-15-Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS BATIMORE Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours 219-40-7274 1 □ M 2 🕊 F Director 68 Yrs. MD 05-14-1943 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Examiner must be notified at Director MD BALTIMORE 1X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21205 1705 E. EAGER USA "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify. Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.

Is marked other than "nature": 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HEAUTHCARE Important: If item 27 is marked other that any injury or other traumatic event, the NURSING AIDE 2012 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANNIE RUTH ASHBY JOHN FORTSON FEBRUARY 15, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3811 CHATHAM Rd. BATIMORE, MO. 21215 DARREN MOBLEY (SON IN LAW) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 2/23/2012 BATIMORE, MD ODDLAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNDLANSONS PA 21. Signature of Funeral Service Licer ROAD. BAND, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate rval Retween Onset and Death Immediate Cause (Final Physician/ LUNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death
Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate I 2 No 1 Yes Division of Vital To the Hospital or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28c. Injury at Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? Investigation
6 Could not be 2 🗌 No Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) -4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar

State

SHIRLEY BARNES

TIMONIUM.

MD 21093

2300 DULANEY VALLEY RD.

nd address of person who completed cause of death (Item 23a) (Type, Print)

32'. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Rebruary 10 25 4 M Physician/ 2012 Broadwater Louise В. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center 8. Date of Birth (Month, Day, Jun. 17, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday, **Funeral** Months Hours Maryland 1 🗆 M 2 🔀 F 95 216-46-1951 Director Usual Residence of Decedent 28a-f shov 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland Carroll Union Bridge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21791 U.S.A. 5665 Middleburg Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 2 🔀 No Completed by 1 Never Married 2 Married Yes 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give White 3 X Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry public school/ 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home teacher/ homemaker 12 5+ Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Carrie Gladhill Lowell Mason Birely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Grossnickle/ daughter 302 College Ave. Frederick, MD 21701 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Union Cemetery 2/16/2012 nr. Union Bridge, MD 21. Sig y uz o Fy ral Service License 22. Name and Address of Facility Hartzler Funeral Home apparine Union Bridge, MD 21791 6 E. Broadway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ assive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Physician/Medical Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has performed 1 Yes 2 No this certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 은 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d Date signed (Month, Day, Year) 29b. Signature and title of certific 52035 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D120 CHACKO Stone 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Boblitz Orlando Henry February 16 2012 1:46 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll 60 W. Main St., Apt. Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) (Month, Day, Year) Apr. 2, 1936 Hours 1 🛛 M 2 🗆 F Months Days Director Maryland 217-38-2030 75 Apr. Usual Residence of Decedent show iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Westminster Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21157 60 W. Main St., Apt. 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked any injury or other. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☒ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) book distribution Elementary/Seconday (0-12) College (1-4 or 5+) maintenance worker center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mamie Zimmerman unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanna L. Smith/ companion 60 W. Main St., Apt. 2 Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) All County Cremation 2/21/2012 Sykesville, MD Signature of Freneral Service Licens 22. Name and Address of Facility Hartzler Funeral Home Broadway Union Bridge, MD 21791 6 Ε. 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ovonav disease or condition Medical resulting in death) Due to (or as a conservence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a s the burial-Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina injury 2 No 1 Tes 2 Accident
3 Suicide
4 Homicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and Ne 29c. License number 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) 5910 Washington 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #7 & 18 per FH g924 of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 02^{Mont} 2012 3:00 A Mary Louise Beard Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Brightview Avondale Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 0371171928 **Director** 137-22-7806 83 Yrs. Newark, NJ Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director 1 Yes 2 X No MD Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21014 USA 128 W. Ring Factory Rd., #1226 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Homemaker Own Home other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Thomas Thorne Kenneth E. Carrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sl
Department of Health ar
Important: If item 27 is, 1232 Seminole Dr., Ft. Lauderdale, FL 33304 Julie Haan - Daughter 3altimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Theo C Auman, Inc. 1 Burial 2 X Cremation 3 Removal from State 02/14/2012 Reading, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Signatur Luneral Servi stold. Valley, Inc., 10 W. Padonia Rd, Timonium 21093 #larv Part 1. Er e the disease, or co shock, r h art failure. List only s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest icatio Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ mo. 9 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician; The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ပ္ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one 29b. Signature and the of certifie 00039258 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. Mai Phan #206 Bel AN MD 21014 awrence 31. Date filed (Month, Day, Year) State FEB 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 2 0 1 2 0 1 7 6 7 | | | | | | | | | | | |
|--------------------------------|--|--|---|--|--|------------------------------|---|--|--|--|--|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | erinicate of Death | Reg 2. Date of Death | . No. / | 04/6/ | | | | | |
| | Physicia Medic | | JANICE ELLEN BEECHING-PIEPER | | Month February | Day 14, 2012 | 3. Time of Death 3:37 P M | | | | | |
| | Examin | | 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Deat | h | | | | | |
| · waysawal | | | 11613 Le Baron Terrace 5. Social Security Number 6. Sex 7. Age (In vrs. last birthda | Silver Spring | | Montgome | 1 | | | | | |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 1 1 1 2 1 1 2 1 1 2 1 1 2 1 2 1 2 1 | Months Days Hours Min | 8. Date of Birth (Month, Day, Ye. Sep • 13, | ^{ar)} 1950 9. Birt | thplace (State or Foreign Untry) Ohio | | | | | |
| | d t t | L | Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or | | | | | | | | | |
| | arylan a-f sh fied a | Director | | | | | 10d. Inside City Limits 1 ☒∑es 2 ☐ No | | | | | |
| | or 28 or 28 e noti | Dir | 10e. Street and Number | | | | | | | | | |
| | with s 23a ust b | Funeral | 11613 Le Baron Terrace | 20902 | ľ | U.S.A. | , | | | | | |
| | death items items | | 11. Marital Status 12. Was Decedent Ever in U.S. 1. Armed Forces? | Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto | | 14. Race - Ame | | | | | | |
| 36 | after il", or xamir | d by | 1 Never Married XX Married 1 Yes 2XXNo | 1 ☐ Yes 2XX No Specify: | radar, etc.) | Black, White Specify: Cau | | | | | | |
| 9 | hours natura lical E | lete | 15. Decedent's Education 16a. De | cedent's Usual Occupation | 16 | b. Kind of Business | | | | | | |
| 218 | iin 72 ie. han "t | Completed | (Specify only highest grade completed) (Gi Elementary/Seconday (0-12) College (1-4 or 5+) | ve kind of work done during most of work DO NOT use retired) | ing | b. Tang of Business | model y | | | | | |
| 2 | d with lygien ther tl nt, the | Be C | 5 + Cou | ederal Go | vernment | | | | | | | |
| Baltimore, Maryland 21215-0036 | be file antal F ked or | To B | 17. Father's Name (First, Middle, Last) Edwin S. Beeching | | e (First, Middle, Maid | , | | | | | | |
| ary | nd Me | | | AGTIANNA ailing Address (Street and Number or Rura | J. Franse | _ | Codel | | | | | |
| Š | and 2 st Health a tem 27 is | | | 613 Le Baron Terra | | r Spring, | · · · · · · · · · · · · · · · · · · · | | | | | |
| ore | of He of He If iten | | 20a. Method of Disposition 1 ☐ Burial ※XX Cremation 3 ☐ Removal from State 20b. Place of Discernetery, c | position (Name of rematory or other place) | | c. Location - City or | | | | | | |
| Ë | : Pag tment tant: jury o | | 4 Donation 5 Other (Specify) W. Arun | del Crematory 2/20 | /2012 (| Odenton, 1 | Maryland | | | | | |
| Bal | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | | 22 Name and Address of Facility Donaldson Funeral | | | | | | | | |
| | | Н | 23a. Part 1. Enter the disease, or complications that caused the death. Do not e | 313 Talbott Avenue of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying. | | Maryland | 20707 Approximate | | | | | |
| 46 | shock, or heart failure. List only one cause on each line. Immediate Cause (Final | | | | | | | | | | | |
| | Medical Examiner | | disease or condition resulting in death) A Malignant Gliom Due to (or as a consequence of): | a | | | 9 Months | | | | | |
| | | er | Sequentially list conditions, b. | | | | | | | | | |
| | red nsit | Examiner | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (or sease or initiary | | | | | | | | | |
| | execui an and ial-tra | Exa | that initiated events resulting in death) Last c. Due to (or as a consequence of): | | | | | | | | | |
| 09 | ate be executed physician and the burial-transit | dical | d | | | | | | | | | |
| 387 | artifica ding pi | /Me | IF FEMALE: | | | | | | | | | |
| Box 687 | eath certificat attending ph | cian | In the past 12 months: | B ☐ Ectopic pregnancy | | 23d. Date of deli Month | ivery Day Year | | | | | |
| B | requires that the de been signed by the should be detached | Physician/Me | 1 ☐ Yes 2 X No 4 ☐ Pregnant at time of death 5 g ☐ Unknown | | | | | | | | | |
| P.O. | s that gned k | by | Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause given in Part I. | 23e. Did tobaco | co use contribute to | the cause of death? | | | | | |
| rds, | een si | ted | | | 1 🗆 Yes | 2 🔀 No 3 🗆 Pr | obably 4 🗆 Unknown | | | | | |
| OS (| The law racate has by page 2 sh | Completed | | | 24a. Was an autopsy | prior to c | opsy findings available completion of cause of | | | | | |
| m m | sician: The certificate rector, pag | e Co | 25. Was case referred to medical | | 1 Yes 2 2 | I? death? No 1 ☐ Yes | 2 X No | | | | | |
| /ita | Physician: rthis certifica ral director, p | To Be | examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpat | 26. Place of Death (Check | | a 🗆 au 🙃 | | | | | | |
| of | ng Phy ter thi neral | | 27. Manner of Death 28a. Date of injury 28b. Time | of 28c. Injury at | me 5 X X esidence 28d. Describe how in | | 14) | | | | | |
| on | tendir leath. or; Af the fu | ifica | 1 ⚠ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be | M 1 Yes 2 No | | | | | | | | |
| Division of Vital Records, | Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death. Funeral Director. After this certificate has been signed by the attending physician and Funeral Director, Parter this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit | Certificate: | 4 Homicide determined 28e. Place of Injury - At home, farm, shullding, etc. (Specify) | street, factory, office | 28f. Location (Street City or Town, St | | al Route Number, | | | | | |
| | Hospital 24 hours a Euneral D | edical | 29a. Certifier 1X Certifying Physician: To the best of my knowledge, deat | boccured at the time, date and place, an | d due to the cause(s |) and manner as sta | ted. | | | | | |
| | To the Hos within 24 ho To the Func completed f | (Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check one) (Check one) (Check only one) (Check only one) (Check on | | | | | | | | | | |
| | To t | | 29b. Signature and title of gentifier | 29c. License number | 29d. | Date signed (Month | , Day, Year) | | | | | |
| | | | 20 Name and address of povers who completed a very fit with the 200 T | D 43083 | F | eb. 15, 2 | 2012 | | | | | |
| | | | 30. Name and address of person who completed cause of death (Item 23a) (Type George Sotos, MD 9707 Medical Cente: | r Drive #300 Pocks | ville. Mar | vland 20 | 850 | | | | | |
| | Stat | е | 31. Date filed (Month, Day, Year) FEB 2 1 20 12 Age Signature | base | , 1101 | 2 | | | | | | |
| | Registra — | ır | LERSI MIS VENUE L | 7 | | | | | | | | |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2perPHYS, 6925, 3/6/2012, WS
State of Maryland / Department of Health and Mental Hygiene

| | | 1 | For State Registrar | (| Certificate of Death | Reg | 1. No. 2012 04768 |
|----------------------------|--|------------------|---|--|---|--|---|
| | Physicia | n/ | 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month FEBRUARY | Da 20 Year 29, 2012 3. Time of Death 4:15A M |
| | Medic Examin | | TED TRACY BARNHILL 4a. Facility Name (if not institution, give street and num | ber) | 4b. City, Town, or Location of | | 4c. County of Death |
| | | | GILCHRIST | 7 0 11 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- | TOWSON | | BALTO . 9. Birthplace (State or Foreign |
| | Funeral Director | | 5. Social Security Number 219-60-6048 Usual Residence of Decedent | 7. Age (In yrs. last birtho | Months Days Hours | Min. Month, Day, Ye APRIL24, | |
| | faryland Ba-f show tified at | Director | 10a. State 10b. County HARFORD | 10c. City, Town | or Location BEL AIR | | 10d. Inside City Limits 1 □ Yes 2 <mark></mark> XNo |
| | with the N s 23a or 2 ust be no | Funeral Di | 10e. Street and Number 824 FLINTLOCK DRIVE | 1 | 10f. Zip Code 21015 | 10 | g. Citizen of What Country? USA |
| 036 | mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland narment of Heath and Mental Hyglene. sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show nortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at it. | þ | 11. Marital Status 1 □ Never Married 2 X Married 1 □ Nidowed 4 □ Divorced 12. Was Dece Armed Fo 1 □ Yes Give If Yes, Give Year or Date of the Properties | e | 13. Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☒ No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE |
| 21215-0036 | in 72 hour e. nan "natu Medical | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1 | | Decedent's Usual Occupation Give kind of work done during most ife. DO NOT use retired) | of working | 6b. Kind of Business/Industry |
| 121 | d with tygien ther th | Be C | 12TH 17. Father's Name (First, Middle, Last) | | DIRECTOR 18 Moth | er's Name (First, Middle, Ma | CONSTRUCTION iden Surname) |
| and | be file ental I ked o ic eve | 10 | DANIEL D. BARNHILL | | | IRGINIA SMIT | |
| lary | should and M is mar aumat | 3 | 19a. Informant's Name/Relationship (Type, Print) | 19b. | Mailing Address (Street and Number | er or Rural Route Number, C | ity or Town, State, Zip Code) |
| Σ, | and 2 s fealth sm 27 her tra | | KATHY BARNHILL S | | 24 FLINTLOCK DRI | | MD. 21015 Oc. Location - City or Town, State |
| Baltimore, Maryland | permit. Page 1 a Department of H Important: If ite any injury or ot | | 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) | | /, crematory or other place) IC CREMATORY | 2-24-2012 G | LEN BURNIE, MD. FUNERAL HOME OF BEL |
| Ba | permit. Pag Department Important: any injury o | Į. | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facilit | , | AIR, MD. 21014 |
| and. | Physician/ Medical Examiner | ner | Sequentially list conditions, if any, leading to immediate Due to | caused the death. Do not ch line. | nic cancer | cardiac or respiratory arrest | Approximate interval Between Onset and Death |
| 8760 | ificate be executed ig physician and as the burial-transit | Medical Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c | (or as a consequence o | n): | | |
| Box 6 | Physician: The law requires that the death certific this certificate has been signed by the attending I rail director, page 2 should be detached for use as | Physician/Me | in the past 12 months? | tcome of pregnancy Birth 2 Fetal death gnant at time of death nown | 3 Ectopic pregnancy 5 Other (specify) | | 23d. Date of delivery Month Day Year |
| s, P.O. | requires that the bear signed by should be deta | β | Part II. Other significant conditions contributing to d | leath but not resulting in | n the underlying cause given in Part | 1 | acco use contribute to the cause of death? s 2 □ No 3 MProbably 4 □ Unknown |
| Division of Vital Records, | sician: The law requ certificate has beer lirector, page 2 shou | Completed | | | | 24a. Was an autopsy perform 1 Yes 2 | 24b. Were autopsy findings available prior to completion of cause of death? No 1 \sum Yes 2 \textstyle Yeo |
| ital | ician: certifica rector, | Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: | | | ath (Check only one) | ace of other (specify) hespire |
| n of V | ding Phys h. After this funeral dii | sate: To | 27. Manner of Death 1 Natural 5 Pending 28a. Date (Mor | | | ursing Home 5 Resider 28d. Describe hov | ice y a calci (epeciny) |
| Divisio | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director. | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place build | e of Injury - At home, far ing, etc. (Specify) | rm, street, factory, office | 28f. Location (Stre City or Town, | eet and Number or Rural Route Number, State) |
| _ | To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b | Medical | 29a. Certifier (Check only one) Certifying Physician: To the base only one) Certifying Nurse Practitione | sis of examination and/or | vledge, death occurred at the time, do | ccurred at the time, date and ate and place, and due to the | cause(s) and manner stated. |
| | | | 29b. Signature and title of certifier | | 29c. License number | 2303 | Ad. Date signed (Month, Day, Year) February 20 2012 |
| | 10 m | | 30. Name and address of person who completed cau | se of death (Item 23a) (| Type, Print) 6701 N Ch | only St | February 20 2012 This UN M) |
| | Sta Registr | | 31. Date filed (Month, Day, Year) 32. I | Registrar's Signature | all | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 04769 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 18, 2012 7:00p M Herbert Berkey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 211 Eider Court Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 216-28-1282 **Director** 1 XM 2 🗆 F 80 Maryland 1931 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director MD Harford Havre de Grace 1 Yes 2 X No 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? must be r Funeral 211 Eider Court 21078 USA items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. an "natural", or iter Medical Examiner Black, White, etc. 1 X Yes 2 No Army If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. d other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel Steelworker 8th event, Be filled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic ever ည Frank Nelson Berkey Caroline Anna Fischer pe and 2 should 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 211 Eider Ct., Stephanie A. Jackson Havre deGrace, Md. 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 🗶 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 2/22/2012 Baltimore, MD Oaklawn 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

Maria H. Jan 22. Name and Address of Facility Joseph N. Zannino Jr. FH 263 S. Conkling St. Baltimore, MD 21224 ann 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as ice of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) attending physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be to 4 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No ō Year Month Day been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Les 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? 1 Yes 2 LAO completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural Accident injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖵 👉 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 06-2011

State

Registrar

onth, Day, Year)

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# 29c, perDVR. G932, 10/25/2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Helen Isabella Bushek Physician/ Year 1010 AM FEBRUAR) Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8, Date of Birth **Funeral** 9. Birthplace (State or Foreign 212-28-7042 Director Marvland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Halethorpe 1 🗆 Yes 2 🏲 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 Second Avenue 21227 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Administration Government. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Florida Suit William Edgar Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
106 Second Avenue Halethorpe, Maryland 21227 Teresa Maxfield daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Veterans Cem. February 17, 2012 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. (270 237 E. Patapsco Avenue Baltimore, MD 21225 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final CEREBROVASCULAR ACCIDENT Onset and Death ^onysician/ disease or condition resulting in death) DAY Medical Due to (or as a consequence of) Examiner UNKNOWN VASCULAR DISEASE PERIPHERAL Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 4 Pregnant at time of death Month Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COLON CANCER, DIABETES Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 1 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sindhuja 2/12/2012 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229. BALTIMORE, MD AVENUE. 31. Date filed (Month, Day, Year) FEB 2 1 2012 32. Registrar's Signatu State

Registrar

EN

| | | Please | Type or Pri | nt in Bla | ack Inc | lelible Inl | k. Ensure A | All Copie | s Are | Legible | | |
|---|------------------|--|---|--------------------|----------------|--|--|-----------------------------------|----------------|---|---------------------------------------|-------------|
| | | For | State of Ma | aryland / | | | lealth and N | /lental Hy | giene | | | |
| | | State Registrar | -41 | | Certi | ficate of L | Death | | Reg. No. | 2012 | 2 11 | 771 |
| Physicia | | Decedent's Name (First, Middle, Las | Thomas P | . Brown | n, III | | | 2. Date of De Month Februal | | 2013 | 3. Time of 11:55 | |
| Medic Examin | | 4a. Facility Name (if not institution, give | | | 4 | | Location of Death | Tebraa | 4c. | County of Dea | ath | , 1 |
| Funeral | | 5. Social Security Number 6. Se | | e (In yrs. last bi | | If Under 1 Year | If Under 24 Hrs. | 8. Date of Bir | th | | rthplace (State of | r Foreign |
| Director | | | X M 2 □ F | 80 | Yrs. | onths Days | Hours Min. | (Month, Da | y, Year) | C | ountry) | |
| nd how at | 'n | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Tov | wn or Locat | ion | | December | 10, 1 | 1931 Wasi | nington, | |
| Maryla 8a-fs uified | Funeral Director | Maryland Montgom | ıery | | | Chevy C | hase | | | | 1 X Yes | 2 🗌 No |
| h the 3a or 2 be no | al Di | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citi | zen of What C | ountry? | |
| ith witims 2% | ner | 5610 Wisconsin A | venue #208 | | 10.14/- | | 20815 | : | | nited S | | |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | þ | 11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced | Armed Forces? | No | 4.5 | es, specify Cuba | ispanic Origin? (Spe n, Mexican, Puerto Specify: | Rican, etc.) | - 1 | 14. Race - Am Black, Whi Specify: W | | |
| nours natura ical E | letec | 15. Decedent's Ed | Year or Dates. 1 | | | t's Usual Occup | ation | | | nd of Business | | |
| ithin 72 ene. • than "r he Med | Completed | (Specify only highest gra | ade completed) College (1-4 or 5 5+ | +) | | d of work done c NOT use retired) Lawyer | luring most of work | ing | ľ | vate Pr | · | |
| iled will Hygin | Be | 17. Father's Name (First, Middle, Last) | | | | Dawyer | 18. Mother's Name | e (First, Middle, | | | actice | |
| ld be f Menta arked | 잍 | Raymond Thomas Br | own_ | | | | Beatrice | Culler | n | | | |
| shoul h and 7 is m raum: | | 19a. Informant's Name/Relationship (T) | | | | | and Number or Rura | | | | | |
| and 2 Health tem 27 | | Alicia Brown / Wi | <u>fe</u> | | | isconsi on (Name of | n Avenue | | | Chase | | 315 |
| Page 1 and ment of Heal ant: If item 2 ury or other | | 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5) | | cemet | tery, cremat | ory or other plac | | lary 18, 012 | | | Marylar | nd |
| permit. Departi Import any inj | | 21. Signature of Chaparat Service Licens | see MO16 | 519 | Rőb 755 | ame and Address ert A. Pun 7 Wisco | s of Facility Tiphrey Fune nsin Aver | ral Home, | Beth | esda-Che | evy Chase, | Inc. |
| | | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of | plications that caused | the death. Do | | | | | | , | Approximate Interval Bety | е |
| Physician/ | | Immediate Cause (Final disease or condition | Kidney | | : | | | | | | Onset and D | leath hs |
| Medical Examiner | | resulting in death) | Due to (or as a | a consequence | e of): | | | | | | | |
| | ner | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a | a consequence | e of): | | | | | | | |
| executed an and rial-transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | c | | | | | | | | | |
| oe exec ician al burial-l | = 1 | resulting in death) Last | Due to (or as a | a consequence | e of): | | | | | | | |
| icate k phys ss the | ledic | | d | | | | | | | | | |
| h certifica tending p or use as | Physician/Medica | | | | | | | | | 23d. Date of de | | |
| ne death | ysic | | | | | | | | | Month | Day Y | 'ear |
| es that the dea signed by the a be detached t | by P | Part II. Other significant conditions co | ontributing to death br | ut not resulting | g in the und | erlying cause giv | en in Part I. | 23e. Did to | obacco us | se contribute t | o the cause of de | eath? |
| requires been sig should b | ted | | | | | | | 1 🗆 | Yes 2 | No 3□F | Probably 4 🗌 (| Jnknown |
| has be | Completed | | | | | | | 24a. Was autor | psy | | utopsy findings a completion of ca | |
| sician; The law I certificate has t lirector, page 2 s | | 25. Was case referred to medical | | | | ne Pla | ace of Death (Check | 1 Tes | ormed? 2 No | | s 2 🗆 No | |
| ysician; is certific director, | To Be | examiner? | Hospital: | ent 2 ER/C | Outpatient | Othe | | | dence 6 | Other (Spec | cify) | |
| ding Ph h. After thi funeral | | 27. Manner of Death 1 X Natural 5 Pending | 28a. Date of injur (Month, Day | y 28b. | Time of injury | 28c. Injury work | at | 28d. Describe h | | | | |
| ttendi death stor: A y the fi | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be | e - | n: At home f | faun atvast | M 1 🗆 | Yes 2 No | 0051 11 15 | | | | |
| ital or A irs after al Direc led in by | | 4 Homicide determined | 28e. Place of Inju building, etc | . (Specify) | | | | City or Tow | n, State) | | ural Route Numbe | <i>∋r</i> , |
| To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu | Medical | 29a. Certifier 1 Certifying Physic (Check 2 Medical Examinonly one) 3 Certifying Nurs | sician: To the best of r iner: On the basis of ex se Practitioner: To the | kamination and/ | or investiga/ | tion, in my opinio | n, death occurred at | the time, date a | and place, | and due to the | cause(s) and mar | ner stated. |
| To th Vithi To th COTI | | 29b. Signature and title of certifier | | , , , | 7 / 2 | 29c. License | | | | e signed (Mont | | |
| Wals | | 15/crom | url - | | | D23 | 600 | | Feb | ruary | 16, 2012 | 2 |
| 301,1 | | 30. Name and address of person who c Bruce Kressel, M. | | | | | 25 Charm | Chase | Mon | bactv | 20815 | |
| Stat | e | 31. Date filed (Month, Day, Year) | 32. Registra | r's Dignature | I IIVE | nue #11. | 25, OHEVY | onase, | 11dL | утани | 20017 | |
| Registra | ır | FEB 2 1 2012 | Charre | A. 100 | 1185 | | | | | | | |

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

| | | For State Registrar | Pleas | se Type or State o | | ind / Dep | | of H | lealth | | - | | ie 20 | ible. | 04772 |
|--|--------------------|---|-------------------------|--|----------------------|-------------------------|--|------------------------|-------------------|------------------|----------------------------------|--|---|-----------------------|--|
| Physicia Medic | | Decedent's Name (Fig. 1) | | · · | lanken | baker | - | | | - | 2. Date of De Februa | eath | Day 15, | 2012 | 3. Time of Death 6:00 A M |
| Examin | | 4a. Facility Name (if not Rockville | _ | | nber) | | 4b. City, To | | Location kvil | | 4c. Count | | | of Death | 1057 |
| Funeral | | 5. Social Security Numb | er 6 | . Sex | 7. Age (In yrs | . last birthday) | If Under 1 | | If Under Hours | | 8. Date of Bi | rth | | 9. Birthpl Count | lace (State or Foreign |
| Director | | 521-09-178 Usual Residence of De | | 1 □ M 2 🗓 F | 95 | Yrs. | William I | | | December 8, 1916 | | | Texa | ** | |
| ıryland a-f sho ied at | ctor | 10a. State 10a Maryland | City, Town or Lo | ocation Silver Spring | | | | | | | 10 | 0d. Inside City Limits | | | |
| the Ma or 28a | Funeral Director | 10e. Street and Number | | gomery | | | 10f. Zip C | | ring | | | 10g. (| Citizen of V | Vhat Count | |
| th with ms 23c must t | ınera | 3701 Inter | nation | | | | | 2090 | | 10.0 | '' V N | | Inited States | | |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | ρ | 11. Marital Status1 □ Never Married3 ☒ Widowed 4 □ | | 12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da | rces? 2 🛣 No e | | Was Decedent f Yes, specify | / Cubai | n, Mexicar | | ecify Yes or No- Rican, etc.) | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 72 hou n "natu Aedica | e Completed | (Specify | | grade completed) | | (Give | dent's Usual (kind of work o O NOT use re | done d | | t of work | ing | 16b. | Kind of Bu | usiness/Ind | lustry |
| ygiene. her tha | | Elementary/Seconda | | College (1 | -4 or 5+) | | retary | | | | | | Educa | ation | |
| be filec ental H ked ot ic even | To Be | 17. Father's Name (First, Charles H | | | | | | | | | e (First, Middle ina A | | |) | |
| should and Ma is mar aumati | | 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 | | | | | | | | | | | | | |
| and 2: Health tem 27 | | Dwight Blankenbaker /Son 219 Kent Oaks Way, Gaithersburg, Maryland 20878 20b. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State | | | | | | | | | | | | |
| Page 1 nent of ant: If il | | 1 ☐ Burial 2 🛣 C 4 ☐ Donation 5 ☐ | remation 3 | ☐ Removal from | State | cemetery, crer | natory or othe | er place | | ebru | iary 19 , 012 | 1 | | • | aryland |
| permit. Departi Import. any inji | | 21. Signature of Funeral | 1/4 | ensee | M013 | O.5 Ro | bert A. | Addres P ump | s of Facilit | unera | al Home/ | Rock | ville, | Inc. | 00050 0005 |
| ALC: Y | T | 23a. Part 1. Enter the dishock, or leart fail | lisease, or co | omplications that of | | 100 | | | | | | | e, Mar | | 20850–2805 Approximate |
| Physician/ Medical Examiner | | Immediate Cause (Fina disease or condition resulting in death) | | _ a | or as a come | estiv. | e b | De | tre | doi | 125.01 | | | | Interval Between Onset and Death |
| ecuted and II-transit | Examiner | Sequentially list conditions, if any saling limit late cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | | | 78 | |
| sate be executed physician and s the burial-transit | हु | resulting in death) Last | quence of): | | | | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans | by Physician/Medio | IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown | ths? | 23c. If yes, outcome of pregnancy 1 | | | | | | | | ry Day Year | | | |
| quires that t | ted by P | Part II. Other significan | t conditions | s contributing to d | eath but not re | esulting in the u | inderlying cau | use giv | en in Part | l. | | | | | e cause of death? |
| e has bee | Completed | | | | | | | | | | 24a. Was auto perfo | psy ormed? | 5 | rior to con leath? | sy findings available npletion of cause of |
| clan: The strifficat sector, pa | Be C | 25. Was case referred to examiner? | medical | | | | | 26. Pla | ce of Dea | th <i>(Check</i> | 1 🗌 Yes | 2 | No 1 | ☐ Yes 2 | 211No |
| Physic this corral dire | 욘 | 1 Yes 2 No | 0 | Hospital: | | ER/Outpatier | | Othe . Injury | 4.10 Ni | | me 5 Resi | | | | |
| ending eath. or, After he fune | Certificate: | 1 Natural 5 2 Accident | Pending Investigat | (Mont | th, Day, Year) | injury | M | work? | ? Yes 2 🗆 | | 28d. Describe | now inju | ury occurre | ea | |
| To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2 | al Certi | 3 Suicide 6 4 Homicide | ☐ Could no determine | 28e. Place | of Injury - At I | nome, farm, str ify) | eet, factory, office 28f. Location | | | | | (Street and Number or Rural Route Number, own, State) | | | |
| the Hosp in 24 hot the Funei | Medical | (Check 2 📙 i | Medical Exa | hysician: To the baminer: On the bas urse Practitioner: | is of examinati | ion and/or inves | tigation, in my | opinio | n, death oc | curred at | the time, date | and plac | ce, and due | to the caus | se(s) and manner stated. |
| 0 1 VV | | 29b. Signature and title | of certifier | 1094 | | | | | number 5 Lf | 56(| 0 | i | ate signed | (Month, D | ay, Year) |
| 10/1 | | 30. Name and address of | of person wh | ` ^ | e of death (Ite | em 23a) (Type, F | | . \ | rors | | | つり | 20 | 902 | 2_ |
| State | 3 | 31. Date filed (Month Da | 9 Year) 20 | 19 532. Re | egistrar's Sign | ture | 4.1 | | | 1 |) | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last, 2. Date of Death Month Year Physician/ Black atherine 1320 SIOS 18 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NorthWest Hospital Seasons'Hospice Baltimore Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Sept. 20, 1915 216-24-5705 96 **Director** 1 🗆 M 💥 🗆 F MD Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Baltimore 1 Yes 2 □ No 10e Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be r Funeral 1843 N. Chester St. 21213 USA items 2 r death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iten edical Examiner r Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examia one. Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify. SpecifyBlack Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Custodian Social Security 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Black Caroline Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean E. Matthews/ Daughter 2104 N. Wolfe St. Balto, Md. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Western Star Feb.25,2012 Balto, Md 21. Signature of Fig. Calvin B. Scruggs Funeral Home Preston St. Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Lementa Cromisals 18 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) Pregnant at time of death Month Day Year s certificate has been signed by the a director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 25. Was case referred to medical injation 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\frac{1}{2}\) Other (Specify) ဂ္ 1 Tes 2-No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: ompletely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 037573 18, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Repell

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2835

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Delores Ε. Brown Feb.15. 10:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Care Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 218-28-7778 77 **Director** Aug.1,1934 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4769 Homesdale Ave. 21206 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 K No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Man life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wayman Brown Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 Meridene Dr. Balto, Md. 21239 Rita W. Davis (daughter) Feb. 22, 2012 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Balto.Co,MD 4 Donation 5 Other (Specific 22. Name and Address of Facility Calyin B. Scruggs I412 E. Preston S Funeral t. Balto 21213 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line nset and Death Immediate Cause (Final Ph_sician/ ahler disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Jause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician ar Physician/Medical Division of Vital Records, P.O. Box 68760 attending p as. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death the Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Dire unomorax 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn this certificate ! 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSPLY 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 \(\sum \) Yes 2 \(\sum \) No iniury 5 Pendina thin 24 hours after death.

the Funeral Director: Af
ompletely filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifler 30. Name and adults ss of person who completed cause of death (Item 23a) (Type, Print) HALLES 6701 32. Registrar's Signature State FEB Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#20a-C. perFH, G924, 2/24/2012 WS State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:15 P Janet Lee Benson February 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6109 Bellinham Court Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 8. Date of Birth 218-12-2308 **Director** 1 🗆 M 2 💢 F 89 10/25/1922 Usual Residence of Decedent 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6109 Bellinham Court # 1131 21210 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna Adele Stifler <u>Lee Ashby Benson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Benson, III / Nephew 321 Princeton Lane Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 28 ^{Date} 2/24/2012 20c. Location - City or Town, State Battimore, Maryland cemetery, crematory or other place)
Lid Ridge Cem.
Litop Service Corp. 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on each line. 1050 York Road Towson, Maryland 21204 Approximate Interval Between Onset and Death Atheroscientie cardio descular bisente Immediate Cause (Final disease or condition resulting in death) Physician/ YEARS Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 📈 No
9 ☐ Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) မ 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 X Natural 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DISF71 Mayland Feb 20,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAWTENCE BURS MD 1734 YORK RD Lutherville MD 21093

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) **FEB 2 1 2012**

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Benson

Janet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death Physician/ Edna E. Cucchiella 18, 1:30 February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Brinton Woods Nursing Home Carroll Sykesville Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours March 21, 220-22-2119 Director 1 □ M 2 🕱 F 1929 Baltimore,MD 82 ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD Carroll Westminster 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 507 High Acres Drive Apt 119 21157 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than State of Maryland Elementary/Secondary (0-12) College (1-4 or 5+) Secretary of Director 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 John P. Stricker Violet X. Smith Department of Health and Important: If item 27 is m any injury or other traums once. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2300 Covered Bridge Garth Baltimore, MD 21234 Michael Pollack- Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February cemetery crematory or other place)
HOLY Recemen
Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 23, 2012 21. Signature of Funeral Service Licen Address of Facility Chapel & Cremation Services Harford Rd. Parkville, MD 21234 Evans 8800 23a. Part 1. Enter the disease, or complications that complete shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Sonsel and Death Immediate Cause (Final Promician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year the g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy certificate has death? 1 Yes 2 No Yes 25. Was case referred to predical or Attending Physician: 26. Place of Deat heck only one) Be Hospital Other: 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director. After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work?
1 \sum Yes 2 \sum No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practifier: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tite of ce 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USING SS ensul 31. Date filed (Month, Day, Year, State FEB Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 20 540 AM Mildred E. Collier Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rosedale Hospital BalTimore 500 212 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign May 04, 1937 1 - M 2 X F Days Months Hours Min. 214-34-4643 74 Director Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Maryland Harford Bel Air 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1310 East Sheridan Place Unit 106 21015 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🗷 No Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after 1 Tes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. Secretary Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Milton Bull Viola Gates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. May Rudolph (Sister) 9832 Gunforge Road, Perry Hall, Maryland 21128 Baltimore. 10 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel 1 Burial 2 X Cremation 3 Removal from State February 22, 4 Donation 5 Other (Specify) 2012 Forest Hill, Maryland Bel Air 22. Name and Address of Facility Ewans Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 Funeral Service Licensee Jeffrey R. Testerman (M01543) 23a. Part 1 Enter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ PSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No 2 - No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury_at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c, License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

9000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. F

31. Date filed (Month, Day, Year)

FEB 2

DUDGTUGT

FRANKLIN SQUALE DR Balto

-20-2012

md

21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $3.45\,A_{M}$ Physician/ February Pay 5 Medical 4c. County of Death **Examiner** BURNIE BALTIMORE WACHINGTON MEDICAL CENTER ANNE ARUNDE . Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country Director 78Yrs. 2-13-33 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10g. Citizen of What Country? Funeral [U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 ₩idowed 4 Divorced Completed JHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ລe filed with... ∽tal Hygiene. `∾r than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygien is marked other th 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RERNICE SILKWORTH e 1 and 2 should be tof Health and Me 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s.
Department of Health a.
Important: If item 27 is any injury or ... MWH OL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State BROOKLYNPARK, M.D. 4 ☐ Donation 5 ☐ Other (Specify) -18-12 21. Signature of Juneral Service 22. Name and Addres of Facility PAURHERTY FUNERAL HOME 23a. Part 1. Enter the de Approximate shock, or heart failure. List of Interval Between Onset and Death Islase Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): signed by the attending physician a Id be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months Month Year Day Pregnant at time of death 2 No Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of de 7? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 No 2 No this certificate 1 Yes Division of Vital Be 25. Was case referred to nedica 26. Place of Death (Check only one) 2 No Hospital: Other: 2 1 🗌 Yes 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer U Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 2012 720VG istrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2012 Cullins Billy Joe Physician/ 17 11:40AM M Feb. Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 7618 2nd St Pasadena Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Director 430-22-5417 88 Malvern Ark. 1 🕱 M 2 □ F Vrs 1923 May 26 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b County 10c. City, Town or Location within 72 hours after death with the Maryland 0a. State Director injury or other traumatic event, the Medical Examiner must be notified Pasadena Maryland Anne Arundel 1 Yes 2 X No 5 10f. Zip Code 10g. Citizen of What Country? 21122 7618 2nd St USA 23a (Funeral "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Completed 3 Divorced 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 conductor railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Important: If fiem 27 is marked on any injury or other Cullins ည Elkins Jesse Nellie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) spouse Elsie Cullins 7618 2nd Street Pasadena Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 2/22/2012 Crownsville Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stallings Funeral Home P.A. 21. Signature of Funeral S 3111 Mountain Road Pasadena MD 21122 23a. Part 1. Enter the dis shock, or heart failur se, or comp List only or at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Co Immediate Cause (Final Physicanial disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown is been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 6 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes ပ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide

Box 68760 P.O. To the Hospital or Attending Physician; The law requires Division of Vital Records, within 24 hours after deati To the Funeral Director: completely filled in by the

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 17, 2012 1:15 P M Cecil Harrison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 3144 Gamber Rd. Finksburg If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, April 1 Funeral **X**XM 2 □ F 235-36-9183 80 1931 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes XXNo MD Carrol1 Finksburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 3144 Gamber Rd. 21048 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married XX Married ģ Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Korea Specify: White "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Gas Station Owner/Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Cora Harman Charles Willie Cecil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3144 Gamber Rd. Finksburg, MD 21048 Linda S. Cecil / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of ^{Date} 21,2012 20c. Location - City or Town, State All Fall (Fab. 1 ☐ Burial XX Cremation 3 ☐ Removal from State ory & Chapel Manchester, MD

22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Crematory & Chapel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Junus 11605 Reisterstown Rd. Owings Mills, MD2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed after death.

Director: After this certificate has been si 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No Yes 2 Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of certifie 29d._Date signed (Month, Day, Year)

State Registrar hington Heights Medical Center, Westminster

address of person who completed cause of death (Item 23a) (Type, Print)

ROJPARA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, c, perffl, G925, 3/5/2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 Day 15 Erna D. Carter Physician/ 05:26 ам Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Social Security Number Birthplace (State or Foreign Country) . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Months Hours (Month, Day, Year) 07/09/1928 578-36-0233 Director DC 1 □ M 2√ F 83 Yrs. Usual Residence of Decede 28a-f show 10c. City, Town or Location 10d. Inside City Limits ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Suitland MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20746 United States 3505 Woodcreek Drive death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ð 1 Never Married 2 Married Yes 2 No Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 → No Specify: Specify: Black Completed 3★ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Administrative Secretary Department of Army Some College other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Webster F. Tweedy Lillian P. Hunter and is 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Angela Davis/daughter 2310 33rd Street SE Washington, DC 20020 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or ot Cedar Hill Cemetery Fort Lincoln 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **2-24-2012** 02-24-2012 Suitland Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 21. Signature of Euneral Service Licensee laring 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OBSTRUCTIVE PULMONAR Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner NENWOHNA Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or injury and the burial-tra that initiated events Due to (or as a consequence of resulting in death) Last nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death g ☐ Unknown 1 Yes 2 9 Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 AMPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed' death? 1 ☐ Yes 2 ☐ Ho Yes 2 No certificate the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certificate: To 1 Impatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injurv 1 Natural 5 Pending Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29c. License numbe ture and title of certifie 29h. Sig D-50 use of death (Item 23a) (Type, Print) ADVENTIST HASP, TAKOMA PARK WASHINGTON ADVENTIST HASP, TAKOMA PARK MD-20012. Amm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 02 2012 Ruth M. Carr 11:00aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Villa Rosa Nursing Home Mitchellville Prince Georges 8. Date of Birth (Month, Day June 28 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 D Hours 96 Director 264-24-2116 June FLUsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland at Director be notified 28a-f 1 Yes 2X No Upper Marlboro Prince Georges 10e. Street and Numbe 10g. Citizen of What Country? ō Funeral 23a raf", or items 23 Examiner must 20774 13216 Fox Bow Drive #102 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: **Black** "natural" Year or Dates ed other than "natur event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Federal Government Clerk f Health and Mental Hygier item 27 is marked other to other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mamie Evans Alexander Jacob Carr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1321b Fox Bow Dr. Unit #102
Upper Marlboro, MD. 20774 19a. Informant's Name/Relationship (Type, Print) Mattie L. Geiger-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metropolitan Crematory 2-17-2012 Alexandria, VA. 4 Donation 5 Other (Specify) Marshall-March Funeral Home Signature of Superal Service Licensee 22. Name and Address of Facility 4308 Suitland Road Suitland, MD 20746 arrane 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Adult failure to Thrive Physician/ disease or condition resulting in death) **Medical** Due to (or as a consequence of) **Examiner** Dementia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Alzheimer physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown ned by the a 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by s been signe should be c 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performed? 2 1 No Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 2 No ္ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending Investigation 2 Accident after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

within 24 hours after de

To the Funeral Directo

completed filled in by th the 2

> State Registrar

only on

29b. Signa

32. Registrar's

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3226

K Rd =300 Lanban MO 20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ February 2012 7:03 A M Charles Glen Comer Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Havre de Grace 941 Nena Ave. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Month, Day, Year) pr. 5, 1947 1**X** M 2 □ F Days Hours Maryland 220-50-0344 64 Apr. **Director** Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Maryland Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 941 Nena Avenue 21078 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Loan Officer Credit Card Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be file lith and Mental H 27 is marked of r traumatic ever မ Darthey Pauline Rhodes permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Joseph David Comer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21403 40 Sandstone Court, Unit I, Annapolis, Maryland Joseph Paul Comer / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Rose Hill Svcs. LLC 2-24-2012 4 Donation 5 Other (Specify) Bel Air, Maryland . Signature of Fundral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examine the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 for use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown detach ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed I ; page 2 should be det þ HYPER TENGION 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available 24a, Was an has prior to completion of cause of death? autopsy performed 1 🗌 Yes 2 🗆 No certificate Yes 2 N Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 🗹 No Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work' Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c, License number 30 Name and address of p pleted cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Corkein ELgene Year Physician/ A OPII Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Seasons Hospice Randallstown Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Numbe **Funeral** (Month, Day, Year) Davs Hours Min 89 Director 1 🛣 M 2 🗆 F 213-16-4052 3/31/22 Marvland Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland ms 23a or 28a-f sho must be notified at Director 1 🗌 Yes 2 🕱 No MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 1230 Pleasant Valley Drive death items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Medical Examiner Armed Forces? Black, White, etc. 5 þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the BGE Electrical Construction of Health and Mental Hygie If item 27 is marked other in other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Anna Engels William Corkrin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Russell G. Corkrin Catonsville, Maryland 21228 11 Kenwood Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Bairing reto Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2/21/12 Baltimore, Maryland @Loudon Park 22. Name and Address of Facility Loudon Park Funeral Home Signature of Funeral Service License 3620 Wilkens Ave. Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ MANNONIA disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li recal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has perform 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 examiner?
1 Yes 2 No Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) has pre-မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 funeral director, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 ANatural 5 Pending s after death. 1 Yes 2 No Accident Investigation Could not be filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifie 20c. License number D37573 18,7012 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Battimere 21709 MD Then Jef 2-837 31. Date filed (Month, Day, Year) ar's Signature 32. Regis State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#6perFH, 6924, 2 21, 2012, WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ CLARK 08:50PM ZENN 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Hospital orth West Randallstown If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 6. Sex ex M 2 K **Funeral** (Month, Day, Year) Months Days 91 Director 06 08 or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No MD NA Windsor Mill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a 3505 Abbie Place 21244 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black "natural", 3 XWidowed 4 ☐ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. 12th grade College (1-4 or 5+)
2yrs Claims Authorizer Social SecurityAdm. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental မ James Holt Blanch Hale permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Clark Jr.-Son 3503 Abbie Place, Windsor Mill, Md 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State King Memorial Park 2/24/2012 Woodlawn, Md Donation 5 Other (Specify) 21. Signature of Funeral Service License March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U darring Cause (Disease or linjury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit De hydrection or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 No Minimum Completed peen (24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No this certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nation 2 ER/Outpatient 3 DOA မ 1 ☐ Yes 2 🔀 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. I Director: After the Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending Accident Investigation the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a To the Funeral C To the Hospital Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Fractioner: Total Annual Content of the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Fractioner: To the best of my knowledge, death ac-29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D67325 16,2012 Mealle M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital, 5401, Old Court Read, Randallshown, MD 21133 Anitha Nallu North West 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

12-01303 Harry Conway, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| | | 1- For State Registrar | | Certific | ate of | Death | | | | 1 | Reg. No. | | | |
|--|--------------|---|-----------------------------------|-------------------------|-------------|---------------------------------|-----------|-------------------|-----------------------------|-------------------------------|-----------------|---------------------|--------------------|-------------------------------------|
| Physici | | Decedent's Name (First, Midd | le,Last) | | | | | | | Date of De | | Voor | | ne of Death |
| ledical Exam | | Harry | | | Conw | ay Ji | c . | | | Month February | Day 13, 2012 | Year | 16 | 40 hrs |
| | | 4a. Facility Name (if not institution | on, give street and num | | | c. City, Tow | | ocation of | Death | | 4c. C | ounty of [| Death | |
|) | | 3605 Springdale Roa | | | | Baltimo | e | | | | | | | |
| Euporol | | 5. Social Security Number | 6. Sex 7 | . Age (In yrs, last bir | thday) | If Under 1 | Year | If Under | 24Hrs. | 8. Date of B | irth(MM/DD | /YYYY) ⁽ | 9. Birthplace | (State or |
| Funeral Director | | | | • | | Months | Days | Hours | Min | | | 6 F | oreign Country) | MD |
| Director | | 219-70-1665 | 1 ½ M 2 F | 55 | Yrs. | | | L | li | 03 | 02 | , , | - Country) | |
| | | Usual Residence of Decedent | | 10c. City, Town | and postin | _ | | | | | - | | 10d I | nside City Limits |
| v any | ĺ | 10a. State 10b. County | *** | | | | | | | | | | | Yes 2 No |
| aryland Sa-f show at once. | 5 | MD N | A | | ватс | imor | 2 | | | | | | | 163 2 |
| aryla Sa-f | 챯 | 10e. Street and Number | | | | 10f. Zip Co | | | | 10g. Citizen of What Country? | | | | |
| death with the Maryland or items 23a or 28a-f sho must be notified at once. | Director | 3415 West Fo | rest Park | est Park Ave 21216 | | | | | | | | U.S | . A . | |
| 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent | | | | | | | | | n? (Spec | ify Yes or N | 0- 14 | | American Inc | dian, 8 lack, |
| ath v | Funera | 1 Never Married 2 X N | larried Armed For | | If Ye | s, specify C | uban, I | Mexican, | Puerto Ri | can, etc.) | | White, 6 | etc. | |
| | | 3 Widowed 4 Di | 1 Yes vorced If Yes, Give Year | 2XNo | 1 | Yes 2X | No | specify: | | | Sp | ecify: B | lack | |
| rs aff ural' | by | 15. Decedent's Education (Spo | or Dates: | completed) 16a. | Decedent | s Usual Oc | cupatio | n (Give ki | ind of wor | k done | 16b. Kin | d of 8usir | ness/Industry | , |
| hou fra | eted | Elementary/Secondary (0-12) | | | during mo | st of workin | g life. D | OO NOT L | ise retired | 4) | | | | |
| 36 thin 7. | ם | 12th grade | na | | Mai | nten | anc | e | | | Sel | lf-E | mploy | ved |
| with with | Compl | 17. Father's Name (First, Middle | | | 1101 | | | | Name (F | irst, Middle | Maiden Su | | | |
| Harry Conway Sr. Viviar No. 19a. Informant's Name/Relationship (Type, Print) Deloris Conway-Wife 1453 North Carey | | | | | | | | | an P | rown | | | | |
| 21215-0036 nuld be filed within 7 Mental Hygiene. marked other than | lo B | Harry Conway 19a. Informant's Name/Relation | | 19 | h Mailing | Address (| Street | and Numb | per or Rus | ral Route N | mber City | or Town. | State, Zip C | ode) |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygies at the Maryland raid Mental Hygies of the "astural", or items 23a or 28s-f she marite event, the Medical Examiner must be notified at once | F | Deloris Conw | | 7747 | 153 | Nort | b C | aro | z St | reet | . Ba | ltim | ore, | Ma1217 |
| MD nd 2 sho alth and alth and a 27 is | | 20a. Method of Disposition | ay-wire | 20b. Place | | | | | | Date | | | ity or Town, | |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Morntal Hygieral. Department of Health and Morntal Hygieral attrail, injury or other traumatite event, the Medical Examiner. | | 1 Burial 2 X Crematic | n 3 Removal from | m State crema | tory or oth | er place) | 01 001111 | | | | | | | |
| Page rent c | | 4 Donation 5 Other S | | On | -Sit | e | | | 2/18 | 8/2012 Baltimor | | | ore, | Md |
| Balti permit. Departm Importu | 1 | 2) Signature of Funeral Service | A Party and Address of Religible | | | | | | | | | | | |
| E P P E | 1 | #300 Wabash Ave, Baltimore, Md 2 | | | | | | | | | | | | 215 |
| Physician | 1 | 23a. Part I. Enter the disease, of | r complications that car | used the death. Do n | ot enter th | e mode of c | lying, s | uch as ca | rdiac or r | espiratory a | rrest, shock | , or heart | . App | roximate Interval ween Onset and |
| IMedical | 00 10 | failure. List only one caus | | nsive Card | liova | scula: | r Di | seas | e | | | | 30. | Death |
| Examiner | ľ (| Immediate Cause (Final diseas or condition resulting in death) | | consequence of): | i I O V G | Jeara | | LUCUL | | | | | | |
| | | Sequentially list conditions, | b. | | | | | | | | | | | |
| | Jer | if any, leading to immediate cancer Fritan Underlying Couse (Disease or injury that initiated professor equitions in death). Lest Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | |
| | Ē | | | | | | | | | | | - 12 | | |
| ed nsit | Examiner | events resulting in death) Last | , | consequence or). | | | | | | | | | ļ | |
| 760, ficate be executed physician and the burial - transit | | X UNPENDED | d. | Ba,pt.II, | 27.pe | r me, | g924 | + 2-2 | 29-12 | Sm | | | | |
| D, be e siciai | edical | | | | _ | | | | | | Logi | D-16.1 | Connection | |
| 76 icate icate | ₹ | IF FEMALE: 23b, Was decedent pregnant in | | utcome of pregnancy | | al death | 3 [| Ectonic | nreanana | ~ | | Date of de onth | Day | Year |
| ertif ding | Ē | past 12 months? | | 1 - 1 C | | ardearn er (S <i>pecif</i> y | | | program | -, | 1 " | | 5-, | |
| Box 68°: death certiff the attending of for use as | Physician | 1 Yes 2 No 9 U | nknown 9 Unknov | | о <u>Г</u> | lei (Opcon) | , | | | | | | | |
| b.O. B that the da ted by the detached is | 든 | Part II. Other significant cond | itions contributing to | death but not resulti | ng in the u | nderlying ca | ause giv | ven in Par | rt I. | 23e. Dic | tobacco us | e contrib | ute to the ca | use of death? |
| P.O es that to igned by | | | - | | | | | | | 1 🗆 Y | es 2 🔲 I | No 3 | Probably | 4 V Unknown |
| S, L uires an sig 1d be | Completed by | Asthma | · | | | | | | | 24a. Wa | s an | 24h W | ere autopsy t | findings available |
| ords, w requir s been s | Set | | | | | | | | | aut | opsy | pri | or to comple | tion of cause of |
| De Constant of the Pool of the | Ę | · | | | | | | | | | formed? | | ath? ✔ Yes | 2 No |
| ital Recician: The l | ပိ | 25. Was case referred to medic | al | | _ | 26. | Place | of Death (| Check or | nly one) | | | | |
| icia s cer rect | 8 | examiner? | Transaction of the second | patient 2 ER/6 | Outpatient | 3 DO | A 10 | Other4 | Nursing | Home 5 | Residence | e 6 🗸 | Other: Scen | ie |
| of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I | 2 | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date of | | Time of Ir | | | at Work | | | e how injury | occurred | <u></u> | |
| n of ding Phy. After the function of the control o | ë | 1 👿 Naharai | (Month, | Day,Year) | | · · | ı 🗆 Ye | es 2 | No | | | | | |
| isior Attence or death | ä | | estigation | of Injury - At home, | form street | | | | - | Rf Location | (Street and | 1 Number | or Rural Ro | ute Number, City |
| Division tal or Attendi rs after death. **I Director: / | <u>\$</u> | | uld not be | or injury - Actionie, | iaiii, succ | ii, laciory, c | illoc bu | iliding, ou | _ _ | or Town | | 211411150 | or real arres | , |
| Table O 29a Cartifier | | | | | | | | | | | a atot-d | | | |
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| To the within To the comple | Medical | 2 🔻 | and manner st | | conyat | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | | | | , | ay, rear) | | | | |
| 0.C.M.E. | | | | | | | | February 14, 2012 | | | | | | |
| se a | | 30. Name and address of person | | | | | | | | | | | | |
| pend | | Russell Alexander M | , | edical Examine | r 900 | W. Baltin | nore : | Street, | Baltimo | ore, MD 2 | 21223 | | | |
| | tate | 31. Date filed (Month, 2012) | r) 32 Re | gister's Signature | ALC: | • | | | | | | | | |
| Regi | | LED S I SOIS | Leave | , ,, | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Chandler Mable 11:17AM February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Season's Hospice Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) 217-24-3210
Usual Residence of Decedent Director 1 M 2 X 82 b7 28 29 MD 28a-f shov 10b. County ms 23a or 28a-f shore must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 🎇 Yes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 U.S.A. 8421 Merrymount Drive items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ò þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Black "natural", 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade Fish Laundry na permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Horace Hall Mary Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Young-Daughter 3919 Sadie Road, Randallstown, Md 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) King Memorial Park 2/23/2012 Woodlawn, Md of Funeral Service License March Afrah West Baltimore, 21215 4300 Wabash Ave, 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cardiormscular Disease A therosclerotic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a nonsequence offattending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be a 24 hours after death.
 Funeral Director: Affer this certificate has been signed by the attending physicis. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year been signed by the a should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 No completely filled in by the funeral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1-Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the F

State Registrar 29b. Signature and title of certifier

HS

ns RajapameM.D

REJAPAKSE M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. 2835

22 Registrar's Sj

29c. License number

5203

D0057465

29d. Date signed (Month, Day, Year)

MD 21209

2/17/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUALY 8:54 AM Patrick Francis Duggan, Jr. 15.2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 10WSON SAINT JOSEPH MEDICAL CENTER . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Months 212-32-7312 Baltimore, MD 1 🔀M 2 🗆 F Jan.2,1936 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Baltimore Parkville 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21234 8723 Stockwell Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 XMarried 1 Yes 2 XNo Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Acme/Giant Elementary/Secondary (0-12) College (1-4 or 5+) Meat Cutter 12 18. Mother's Name (First, Middle, Maiden Surname) IINK 17. Father's Name (First, Middle, Last) Virginia Patrick Francis Duggan, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8723 Stockwell Road Baltimore, MD 21234 Linda Duggan- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1X Burial 2 Cremation 3 Removal from State Parkville, MD Parkwood Cemetery 18,2012 4 Donation 5 Other (Specify) . Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel & 8800 Harford Rd. Parkvi Cremation 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final PROBABLE ACUTE MYOCARDIAL INFARCTION LOURS ase or condition resulting in death) Due to (or as a consequence of) CONGESTIVE HEART FAILURE Due to (or as a consequence of) HORTIC OUTLET RESTRICTION MONTHS Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery Month 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY DISEASE HRTERY 1 Yes 2 No 3 Probably 4 Unknown

Physician/ Medical Examiner Examine

trar

attending physician for use as the buria

signed by the detact

ate has bage 2 s

certificate

that the death certificate be Box 68760

P.O.

Division of Vital Records,

Physician/Medical

þ

Completed

Be

Certificate:

Medical

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

or 28a-f show notified at

9 items 23a or ner must be r

ı "natural", or item edical Examiner n

of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me

permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once.

Medical

death

3altimore, Maryland 21215-0036

Director

Funeral

by

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

24a. Was an autopsy Yes 2 No 26. Place of Death (Check only one)

TOWSON, MARYLAND

24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Was case referred to medica examiner? 2 🗷 No 27. Manner of Death

28a. Date of injury (Month, Day, Year)

1 X Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d Describe how injury occurred

1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide

29a. Certifier

Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSLER DRIVE M.D. NICOL THERESA

31. Date filed (Month, Day, Year) FEB 2

M.D

Registrar

State

DHMH 17 Rev 06-2011

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Downey Sr Teb Joseph Michael 99 20°f*2 0422A Medical cility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4888 Mountain Road Pasadena Anne Arundel Social Security Number 220–36–3428 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) **Director** 1 🙀 M 2 🗆 F 71° August 26 1940 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location notified at Director Maryland Anne Arundel Pasadena 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? ō an "natural", or items 23a o Medical Examiner must be 4888 Mountain Road by Funeral 21122 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 57 - 60white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene. If item 27 is marked other that or other traumatic event, the l Building Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Edward Downey Alice Bridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Downey wife 4888 Mountain Road Pasadena MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I-Important: If ite any injury or oth MaryTand"VAY Cemetery 1 XBurial 2 Cremation 3 Removal from State 2/24,2012 Crownsville Maryland 4 Donation 5 Other (Spec 21. Sign sur- of Funeral Ser 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final Physician/ disease or condition resulting in death) monte Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine any, leading to immediate cause. Enter Underlying Due to for as a consequence of, Cause (Disease or injury signed by the attending physician and deedetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physici Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown this certificate has been signal director, page 2 should I 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my policing death accurred at the time. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D39505 ery M.1) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 Hospital Dr. Glen Burnie, MD.

DHMH 17 Rev 06-2011

State Registrar

12-01395 Darell Gray Duty Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| 2012 | 0 li | 7 | 9 | |
|------|------|---|---|--|
|------|------|---|---|--|

| | | 1- For State Certificate of Death Reg. No. | | | | | | | | | | | | |
|--|-------------|--|--|--------------------------------------|---------------------|-------|---------------------------------------|------------|----------------|----------------------------------|----------------|-----------------------|----------------------------------|--|
| Physicia Medical Examin | ın/ | Decedent's Name (First, Middle Darell Gray | Duty | | | | | | 2 | Date of Dea Month February | Day 16, 201 | | | 3. Time of Death 0805 hrs |
| | | 4a. Facility Name (if not institution Franklin Square Hosp | . • | number) | | | City, Town, or Lo Rosedale | cation of | Death | | | County of altimore | | nty |
| Funeral Director | | 5. Social Security Number 232–54–5112 | 6. Sex | 7. Age (In yr | s. last birthday) | | If Under 1 Year Months Days | If Under: | 24Hrs. Min. | 8. Date of Bi | • | 1 | Foreign | nplace (State or West Intry Virginia |
| т аву | | Usual Residence of Decedent 10a. State 10b. County | | 10c. C | ity, Town or Loc | ation | | | | | | | | 10d, Inside City Limits |
| Aaryland 28a-f show 1 at once. | ğ | Maryland Balti | more | | Esse | | | | | | | 5110 | | 1 Yes 2 No |
| the Mary | Director | 914 N. Marlyn | Avenue | | | 1 | of. Zip Code 21221 | | | | 0g. Citize | U.S | | ry? |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f sho matic event, the Medical Examiner must be notified at once | Funeral | 11. Marital Status 1 Never Married 2 M | larried Armed | ecedent Ever in Forces? 2 X No | H | | Decedent of Hispa specify Cuban, M | | | |)- 11 | 4. Race - White, | etc. | an Indian, Black, |
| s after ral", | ক্র | | vorced If Yes, Give Your Dates: | | | | es 2 X No | | | | | pecify: | | hite |
| hour natu | pleted | Decedent's Education (Spe Elementary/Secondary (0-12) | | (1-4 or 5+) | | | Usual Occupation of working life. D | | | | 16b. Kir | nd of Busi | ness/In | dustry |
| 0036 within 72 giene. | E1 | 17. Father's Name (First, Middle | | 2 | Secu | it | y Guard | 44-WJ- | No | First, M iddle, | | | ive | Repair |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "nat injury or other traumatic event, the Medical Exa | Be | Mack Hanna | | | | _ | | Stell | a Br | cown | | | | |
| MD 2 d 2 shoul lth and M n 27 is m numatic | 의 | 19a. Informant's Name/Relations Karon Sue Suth | | aughtei | 100 | | ddress (Street a | | | | | | | |
| e, M and 2 Health item 2 traun | ŀ | 20a. Method of Disposition | | | | | | | | | | | | |
| Baltimore, permit. Pages 1 ar Department of Her Important: If ite | | | Z Committee S Removal from State | | | | | | | | | | re. | Maryland |
| mit. P partme porta | ı | | Donation 5 Other Specify: HOITY HIII Mem. Gard. U2/20/2012 Balting and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue, Essex, | | | | | | | | | | | |
| E.E.P.E. | 1 | Basel | | | | 40 | 7 Old Ea | ister | nski n Av | zenue, | Esse | ione x, M | ary | Tand 21221 |
| Physician / /Medical | 7 | 23a. Part I. Enter the disease, or failure. List only one cause | rt I. Enferttie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock live. List only one cause on each line. Pneumonia complicating Hypertensive Atherosci | | | | | | | | | | tie | Approximate Interval Between Onset and |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) | | vascula a consequence | | se | Right I | lip F | ract | ture | | | | Death |
| | | Sequentially list conditions, | b | | | | | | | | | | | |
| | miner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated | | a consequence | e of). | | | | | | | | | |
| recuted and - transit | Exa | events resulting in death) Last | Due to (or as d. | a consequence | e of): | | | | | | | | | |
| ज ज ज | n/Medical | X UNPENDED IF FEMALE: | | 23a,27, | | g9 | 27 5–16- | -12 s | m | | Laci | D-12.1 | | |
| | Physician/N | 23b. Was decedent pregnant in the past 12 months? | he 1 Live | birth Inant at time of | 2 🔲 | | death 3 (Specify) | Ectopic p | pregnanc | Э | | Date of de Ionth | Da | ay Year |
| P.O. Be s that the des gned by the s | | Part II. Other significant condit | tions contributing | to death but no | ot resulting in the | und | erlying cause give | en in Part | I. | 23e. Did to | obacco us | e contribu | ute to th | ne cause of death? |
| S, P. uires th n signe | ed by | Hypertensive | Atherosc | lerotic | Cardio | va: | scular D | iseas | se, | | | | - 1117 | ably 4 V Unknown |
| of Vital Records, ig Physician: The law require the tark from the tark f | Completed | Chronic Obst | ructive P | ulmona | ry Disea | ıse | | | _ | 24a. Was autor perfo | | pri | | opsy findings available ompletion of cause of |
| Vital Rec | | OF Wassesser | | | | | 06 Pl | D#- (0 | D1 | 1 ✓ Yes | | | ✓ Yes | 2 No |
| /ital | ă, | 25. Was case referred to medical examiner? 1 ✓ Yes 2 No | Hospital: 1 | Inpatient 2 | ✓ ER/Outpatie | nt 3 | 26.Place of | h — | | Home 5 | Residenc | e 6 | Other: | |
| ing Phy After th | ٤ | 27. Manner of Death | | e of Injury | 28b. Time o | | | | | 8d. Describe | | | | |
| ion tendir eath. for: A | cation | | | | | | | | | | | | | |
| Division pital or Attendii ours after death. seral Director: A | | Suicide Suicide Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 14 N Essex, MD. | | | | | | | | | Number 4 N. | or Rura Mar | al Route Number, City: Lyn Ave. | |
| e Hot 24 h e Fur | Medical C | (and an and | hysician: To the be miner:On the basis and manner | of examination | - | | | | | | | | | |
| HSHS | Ĭ | 29b. Signature and title of certific | | , | A | | 29c, License r | | | | | - | , | th, Day, Year) |
| | | 30. Name and address of person | 11 | 1/1/ | am 222) | | O.C.M. | E. | | | Febru | ary 17 | , 2012 | 2 |
| | | Zabiullah Ali, M.D. | Assistant Medi | cal Examin | er 900 W. | Bali | timore Street | , Baltim | ore, N | 1D 21223 | | | | |
| Sta Regist | 100 | 31. Date filed (Month, Day, Year) | 2012 | tegistrar's Sign | | Ka | 1 | | | | | | | |
| DHMH 17 Rev 1/20 | 01 | | | | | | | | | | OGME | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Fob Month Month Physician/ 20012 10 KAREN DANIEL Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner Hospital Bal Timore of Baltimore Ci Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 579.98.0021 1 M 2 XX Director 6.28.1965 46 Usual Residence of Dece 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f sho with the Maryland Director XX Yes 2 No **CAITHERSBURG** MD MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 20879 1605 TAMYARD HILL RD. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 1 Never Married 2 Warried Yes 2 No Completed by be filed within 72 hours after BLACK 1 Yes 2XX No Specify: 21215-0036 If Yes. Give 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry event, the Medical 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.
27 is marked other than ranmatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Health & Human Services Disability Client ASST 12 Be 18. Mother's Name (First, Middle, Maiden Surname) DS Baltimore, Maryland 17. Father's Name (First, Middle, Last) JOSEPHINE CAMPBELL ပ CHARLES EDWARD HALL permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any july or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Low 19a. Informant's Name/Relationship (Type, Print) 1605 TAMYARD HILL RD. GATHERBURG, MD 20879 BERT DANIEL 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State LAUREL HILL ,NC PATTERSON CEMETERY 4 Donation 5 Other (Specify) Feb 16, 2012 . Signature of Funeral Service Lic 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT
426 CRAIN HWY SW GLEN BURNIE, MD 21061 K. GREGORY TNK M01148 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine necve Hospital or Attending Physician: The law requires that the death certificate be executed Vescer attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medica Medical Certificate: To Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1→ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No iniury 1 Natural 5 Pending Investigation ☐ Accident ☐ Suicide within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of Fob (any 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Khosravi, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year,

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 2000 p LEE ANGELA DOOLEY FEB PAMELA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) **Director** 578-98-5998 50 1 🗆 M 2 🕱 F Oct. 6, 1961 GA 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location **Funeral Director** must be notified at 1 Yes 2 X No MD Prince Georges Suitland 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Numbe items 23a 6014 Goodfellow Dr. 20746 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirane, ones. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life, DO NOT use retired) The Elementary/Secondary (0-12) College (1-4 or 5+) Courses at AndrewsAFB 12th Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilbert Dooley Mable Easterly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma Diane Bostic - Sister 6014 Goodfellow Dr. Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 2-17-2012 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Washington National 21. Signature of Funeral Service Licenses Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitlnad, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Cardio Vas. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed Be 25. Was case referred to medica မ

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. within 24 hours a

2 No 1 Yes 27. Manner of Death 1 Natural Accident Investigation 3 Suicide 6 Could not b 4 Homicide

| | | | | 26. Place o | f Death (Chec | ck only one) |
|----|---|---------------------|-----------|-----------------------------|---------------|---|
| Ho | spital: 1 M hpatient 2 🗆 | ER/Outpatient | 3 🗌 D | OA Other: 4 | ☐ Nursing H | lome 5 Residence 6 Other (Specify) |
| 1 | 28a. Date of injury (Month, Day, Year) | 28b. Time of injury | M 2 | 28c. Injury at work? 1 Yes | 2 🗆 No | 28d. Describe how injury occurred |
| е | 28e. Place of Injury - At h | ome, farm, street | t, factor | y, office | | 28f. Location (Street and Number or Rural Route Number, |

| | Certifier (Check | 1. Certifying Physician Medical Examiner: | n: To the best of my know On the basis of examinatio | rledge, death occurr | ed at the time, date and place, and due to the | cause(s) and manner as stated. and place, and due to the cause(s) and manner stat |
|-------|---------------------|---|---|----------------------|--|--|
| | only one) | 3 Certifying Nurse Pr | actitioner: To the best of | my knowledge, death | occurred at the time, date and place, and due to | the cause(s) and manner as stated. |
| 9b. S | Signature an | d title of certifier | Herde al (| pan | 29c. License number | 29d. Date signed (Month, Day, Year) |

| 9b. Signature and title of certifier Attendar Pan | 29c. License number | 29d. Date signed (Month, Day, Y |
|--|---------------------|---------------------------------|
|--|---------------------|---------------------------------|

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year 20:15 PM **Physician** Douskas February 20 Anastasios 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 □XM 2 □ F Greece 58 220-74-8628 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1x Yes 2 □ No Baltimore City ral", or items 23a or 28a-f s Examiner must be notifled Directo MD 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 21224 Greece 621 S. Newkirk Street 'natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Injury or other traumatic event, Be and Mental H Lamprini Siarbas Nicholas Douskas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S. Newkirk St., Baltimore, MD 21224 permit. Pages 1 and 2.3 Department of Health at Important: If item 27 is any injury or other trau Vasiliki Douskas – Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Narkissos Cemetery2/28/12 Greece, Narkissos 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bradley-Ashton Funeral Homa 2134 Willow Spring Road 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung cancer disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit and resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE been signed by ģ Completed should has After this certificate Be မ

Medical Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

or Attending Physician:

Director:

24 hours

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

filled in by the funeral

Certification:

Medical

29b. Signature and title of certifier

| 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregn 1 | al death 3 Ectopic | | | 23d. Date of delivery Month Day Year |
|--|---|-----------------------------|-------------------------------------|--|--|
| Part II. Other significant conditions of | ontributing to death but not re | sulting in the underlying | g cause given in Part I. | | o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ███nknown |
| | | | | 24a. Was an autopsy performed? | |
| 25. Was case referred to medical | | | 26. Place of De | ath Check on one | |
| examiner? 1 Yes 2 No | Hospital: 1 Impatient 2 | ☐ ER/Outpatient 3 ☐ □ | OCA Other: 4 - Nursing | Home 5 Residence | 6 ☐ Other (Specify) |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how in | jury occurred |
| 3 Suicide 6 Could not be determined | 28e. Place of injury - At h building, etc. (Speci | | ry, office | 28f. Location (Street City or Town, Sta | and Number or Rural Route Number, te) |
| | ysician: To the best of my knowniner: On the basis of examination | | | | e(s) and manner as stated. and place, and due to the cause(s) |

29c. License number

RES-000

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

February 20, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SHARON DAUGHERT 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDE HARWOOD MANDRIN IMPATIENT CARE CITY. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Min. Country) **Director** 4-2-42 ANAIGN Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Yes 2 No ANNE ARUNDE 10e. Street and Number 10g. Citizen of What Country? Funeral 5.A. OGS.MEADOW 1060 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Informant's Name/Relationship (Type, Print) LAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1905 DEFOREST DETOREST 20a Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 2-20-12 BENBURUE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Part 1. Enter the disease, or com mediations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between shock, or heart failure. Onset and Death Immediate Cause (Final Physician/ hears disease or condition resulting in death) Medical Examiner Smoll 1 297 Sequentially list conditions, Examiner if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Coroner Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 4 Nursing Home 5 Residence 6 DOther (Specify) 105 /14 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural injury 5 Pendina ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 30 Name and address of per Annapilis 44 < 31. Date filed (Month, Day r's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:00 PM February 2012 Preston Odell Duppins, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll 980 McKinstry Mill Rd. Union Bridge If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 7. Age (In yrs. last birthday) Hours Days (Month, Day, Year) **Director** 220-28-4114 1 X M 2 D F 79 Oct.20, 1932 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 X No Maryland Carroll Union Bridge 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 980 McKinstry Mill Rd. 21791 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ō þ 1 Never Married 2 Married X Yes 2 ☐ No f Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", Completed 3 Divorced Specify. Year or Dates. 1953-55 Black traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12 repairman cement co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William D. Duppins Evelyn Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Virginia Duppins/ wife 980 McKinstry Mill Rd. Union Bridge, MD 21791 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 2/14/2012 4 Donation 5 Other (Specify) Resthaven Mem. Gard. Frederick, MD 21. Signature of Fune al Service License 22. Name and Address of Facility Hartzler Funeral Home Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and D Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the phy as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown been signed by the should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes No 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No neral Director: A Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) le 31. Date filed (Month, Day, distrar's Signature State Registrar

| | | | 1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 04796 | | | | | | | | | | |
|---------|--|---|---|--|--|--|--------------------------------------|-------------------------------------|---|-----------------------|---------------------|--------------------|---|
| | | | _ | State Registrar | | Cer | tificate of | Death | | R | eg. No2 U | 12 | 04/90 |
| - | Phys | nioio. | , | 1. Decedent's Name (First, Middle, Last) | - | | | | | . Date of Deatl | | Year | 3. Time of Death |
| | | edic | al | | De Long | | | | | Februar | y 17,20 |)12_ | 8:10 A M |
| 4 | Exa | ımine | er | 4a. Facility Name (if not institution, give street ar | | | 4b. City, Town, | | of Death | | 4c. County | | |
| | C | | | Stella Maris Hospic 5. Social Security Number 6. Sex | 7. Age (In yrs. la | ast hirthday) | Timon: | | 24 Hrs. 8 | . Date of Birth | | | more place (State or Foreign |
| 1 | Fune Direc | | | 112-20-8049 1 □ M 2 | | Yrs. | Months Days | | Min. | (Month, Day, | Year) | ntry) | |
| | | | | Usual Residence of Decedent | 07 | | | | J | uly 15 | , 1924 | | York |
| | yland -f show | ed at | ctor | 10a. State 10b. County | | y, Town or Loc | | | | | | | 10d. Inside City Limits |
| | e Mar | | Sire | MD Baltimore 10e. Street and Number | | Timoni | 10f. Zip Code | | | 71.4 | | | 1 Yes 2 No |
| | ith th | e l | ra l | | a | | | 093 | | | Og. Citizen of V | | ntry? |
| | ath w | | Funeral Director | 2525 Pot Spring Roa | Decedent Ever in U.S | | Vas Decedent of | Hispanic Ori | | | | | can Indian, |
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| 9 6 | JOS JITS af ural" | EXS | ted | 3 X Widowed 4 □ Divorced If Yea | es, Give r or Dates. | 1 | Yes 2 X | ю Ѕресіту: | : | | Specify: | w | hite |
| | 2 hou | edica | ple | 15. Decedent's Education (Specify only highest grade comp | eleted) | (Give k | ent's Usual Occi and of work done | during mos | t of working | | 16b. Kind of Bu | siness/In | dustry |
| 0 (| 21215-0036 within 72 hours after giene. er than "natural", o | l le | Completed | Elementary/Secondary (0-12) Coll | ege (1-4 or 5+) 4 | life. DC | NOT use retire Re | altor | | | Rea | 1 Es | tate |
| | | ent, 1 | a | 17. Father's Name (First, Middle, Last) | | <u> </u> | | | er's Name (F | First, Middle, M | faiden Surname | :) | |
| ? . | Maryland 2127 2 should be filed within 7 th and Mental Hygiene. 27 is marked other than | ac ev | 의 | Charles Niles | | | | | Nata: | lie St | ewart | | |
| 6 | lary | an a | | 19a. Informant's Name/Relationship (Type, Print |) | | g Address (Stree | | | | | | |
| | - 7 ± 0 ; | | | David DeLong/Son | | | Heaths | Bridge | Road | Conco | ord, MA | 0174 | ¥2 ———————————————————————————————————— |
| COARI | Saltimore, bermit. Page 1 and Department of Hee mportant: If item | 00.00 | | 20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Remova | | lace of Disposemetery, crem | sition (Name of natory or other p | lace) | Feb. $\overset{	extstyle{	iny Dat}}{1}$ | 8. | 20c. Location - | City or To | own, State |
| OY. | it. Pag rtmen rtant: | dinic | | 4 Donation 5 Other (Specify) | At1 | | Cremato | ry | 201: | 2 | Glen I | | |
| FED | Baltimore permit. Page 1 a Department of F Important: If ite | any II | | 21. Signature of Fundal Service Scensee Minael J | Flagle | $egin{pmatrix} rac{22}{\mathbf{L}} \\ \mathbf{l} \end{array}$ | Name and Add emmon Fi 0 W. Pa | ress of Facility uneral donia | Home Road | of Dul Timoni | laney Va Lum, MD | 111ey 210 | 93 ^{Inc.} |
| 1 | | | | 23a. Fart 1. Enter the disease, or complications shock, or heart failure. List only one cause | that caused the death on each line. | h. Do not ente | r the mode of dy | ing, such as | cardiac or re | espiratory arre | st, | | Approximate Interval Between |
| 1 | Physicia | | | | EREBROVASC | | CCIDENT | | | | | | Onset and Death |
| ٦ | Medi Exami | | | D D | ue to (or as a consequ | ience of): | | | | | | | |
| | | | Jer | | ue to (or as a consequ | uence of): | | | | | | \dashv | |
| 9 | d uted | 100 | Examiner | Cause (Disease or injury that initiated events c | | | | | | | | | |
| 13 | ate be executed whysician and the burial-transit | | Ě | resulting in death) Last | ue to (or as a consequ | ience of): | | | | | | | |
| 8 | ate be | | dical | d | | | | | | | | \rightarrow | |
| | certifica anding plants as t | 8 | Me | IF FEMALE: | es, outcome of pregnar | ncv | | | | | 00.1.0.1 | - 6 -1 - 1'- | |
| Dell'On | BOX I death or the attendant | 2 | Physician/Me | in the past 12 months? | Live Birth 2 Feta Pregnant at time of d | ıl death 3 🗀 | Ectopic pregna Other (specify) | | | | 23d. Dat Mo | te of deliv nth | Pery Day Year |
| | he de y the | | hysi | | Unknown | | (-,)/ | | | | | | |
| | that the operation of the contract of the cont | | by P | Part II. Other significant conditions contributing | g to death but not resu | ulting in the u | nderlying cause | given in Part | Ł. | 23e. Did tob | pacco use contr | ibute to t | he cause of death? |
| Å Å | uires puires an sign | | ed t | | | | | | | 1 □ Y€ | es 2 🗆 No | 3 Pro | bably 4 🛣 Unknown |
| | aw rec | 2 | Completed | | | | | | | 24a. Was ar autops | 24b. V | Vere auto | psy findings available empletion of cause of |
| | The Is ate ha | a diameter | 5 | | | | | | | perform | ned? | death? | 2 🗆 No |
| - | cian: cian: entific | , | Be | 25. Was case referred to medical examiner? | | | | Place of Dea | ath (Check o | nly one) | | | |
| 27.7 | T VI Physi this c | 5 | ၉ | T LI Yes 2 A INO | 1 Inpatient 2 Inpa | ER/Outpatien | t 3 LI DOA | | | | | | HOSPICE |
| | JUNISION OT VITAI MECONAS, all or Attending Physician: The law requires 's after death. In Director, After this certificate has been signed in you the funeral director grane? should it | | Certificate: | 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation | (Month, Day, Year) | injury | 28c. Inj wo M 1 | ork? Yes 2 | - 1 | a. Describe no | w injury occurre | Ю | |
| | Atten Atten ar dea | | ŧ | 3 Suicide 6 Could not be | Place of Injury - At ho | | | | | | | er or Rura | l Route Number, |
| | Lalor Saffe | | | | building, etc. (Specify, | | | | | City or Town | , State) | | |
| | DIVISION OT VITAI RECORDS, P.O. BOX 08 (1) To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. The Funeral Director After this certificate has been signed by the attending promoles by filed in by the fineral director nade 3 should be deteched for use as a | and and and and and and and and and and | Medical | 29a. Certifier (Check (Check only one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one | he basis of examination | and/or invest | igation, in my opi | nion, death o | ccurred at th | e time, date an | d place, and due | e to the ca | use(s) and manner stated. |
| | To the | | | 29b. Signature and title of certifier | 1 . / | | | nse number | | | 9d. Date signed | | |
| 1 | | | | Juneag W. | Lete C | RIA | PR | 1270 | 474 | 1 | 2/1 | 7 | 112 |
| | A | - | | 30. Name and address of person who complete | , | , , , , . | | | | | 7 | 7 | |
| | | C | | JUNECIA WHITE, CRNP 31. Date filed (Month, Day, Year) | 2300 DUL 32. Registrar's Signat | | ALLEY R | D. TI | MONTU | M, MD 2 | 21093 | | |
| | | Stat istra | - | FFR 2 1 2012 | January Signal | f A | ac Mad | | | | | | |

FEBRUARY 17, 2012 8:10 a.m.

CARUTH Delong

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 16, 2012 7:35 a M Physician/ Sally J. Dexter Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Parkville 7933 Beverly Avenue If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth . Age (In yrs. last birthday, **Funeral** Days Hours April 12, 1955 214-68-0880 Alaska **Director** 1 🗆 M 2 🗶 F 56 Usual Residence of Deced show 10d. Inside City Limits 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Parkville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21234 7933 Beverly Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 t.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Cole Louise မ Constance W. Coates, Sr. Norman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7933 Beverly Ave., Parkville, MD Edward M. Dexter-husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Serv. Corp. 2/20/12 Towson, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 1050 York Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine Dire to for as a consequence of: cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical P.O. Box 68760 use as t IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregr 3 Ectopic pregnancy
5 Other (specify) atter in the past 12 month Day for Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco se contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? cate has ; page 2 ; 2 🗌 No 1 Yes certificate 25. Was case referred to redical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital Other: 0 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home Residence this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred f Death Certificate: hin 24 hours after death.

the Funeral Director: After
mpletely filled in by the funer Vatural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 32. Registrar's State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month DONAHO STEVEN Februar HN 8:00 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CENTER CARROLL CARROLL HOSPITAL WESTMINSTER 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last hirthday) 8. Date of Birth **Funeral** Days Hours 1 5M 2 F 218-76-127 52 Director Yrs Usual Residence of Decedent 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director New Windsor MD Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? Funeral 23a 1614 Bowersox Rd. 21776 USA items : 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black White, etc. 1 Never Married 2 Married Completed by "natural", or Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: white traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Engineer Hospital and Mental Hygie is marked other Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John W. Donaho Linda Gamber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 siment of Health attach 27 i Steven Donaho-son 1614 Bowersox Rd., New Windsor, MD 21776 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite Date cemetery, crematory or other place) 5 1 ☐ Burial 2X Cremation 3 ☐ Removal from State injury o South Carroll Crem 2-20-12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home homas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Immediate Cause (Final Onset and Death RESPIRATORY Priysician CHRONIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner OBSTRUCTIVE ULMONARY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit BRAIN INJUR ANOXIC and that initiated events resulting in death) Last Due to (or as a consequence of) physician RHABD OMYOLYSIS Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the detached 9 Unknown 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? Completed by Records, DEPENDENCE DEPRESSION 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Division of Vital examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 A Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar 31. Date filed

D69086

Curroll tuspital center

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

SHARMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Feb 16 9:57a ^{Day} 012 Year Ernest William Dieterich Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Westminster Ridge Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 218-18-6508 1 **Ж**М 2 □ F **Director** 85 5-11-1926 MD Yrs Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Carroll Westminster MD 1 🗆 Yes 2 🔀 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 21157 USA 505 High Acre Dr. items 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Examin þ 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 🏋 No Specify. SpecifyWhite "natural" Completed 3 X Widowed 4 Divorced Hygiene. other than "natura ent, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Long Shore Man Cargo 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic even of Health and Mental fitem 27 is marked ပ William Dieterich Mary Spiegel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest Dieterich-son 4111 McMullen Rd., Taneytown, MD 21787 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₹ 1f X Burial 2 \Box Cremation 3 \Box Removal from State Department o Important: If any injury or # b 2-20-12 Baltimore, MD Holly Hills Mem 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home Thomas them-254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Dronom disease or condition Medical resulting in death) a consequence of Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ☐ Live Birth☐ Pregnant a☐ Unknown in the past 12 months? Month Pregnant at time of death ate has been signed by the a page 2 should be detached f Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform death? red 2 No 1 Yes 2 **N** Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 1 Yes 2 100 မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending P 24 hours after death. E Funeral Director: After the teley filled in by the funera Certificate: 28c Injury at 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State

14/1

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ernesto Mendoza, 524 Washington Rd., Suite 120, Westminste.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DUISD?63

ECKHARdt, Patricia

| | | | | Please | Type or Pri | | | | | | | | | | ble. | |
|--|--|------------------|--|--|---------------------------------------|----------------|------------------------|-----------------------------|-------------------------|-------------------------------|-----------|---------------------------------|-------------------------|-------------------|------------------------------------|---|
| | | | For State | | State of M | aryland | | | | | ind M | lental Hy | giene | 20 | 12 | 04800 |
| | | | Registrar | e (First, Middle, Las | st) | | Cer | tificate | OI L | <i>Jeam</i> | | 2. Date of De | Reg. No | o. = V | 1 6-10 | 3. Time of Death |
| | Physicia Medic | | | ia M. Ec | | | | | | | | Month Ó2 | 18 | 20 | Year | 9:50 A M |
| a As | Examin | | 4a. Facility Name (if | not institution, give | street and number) | 10 | 1 | 4b. City, To | | Location of | f Death | | | County of | | |
| | Funeral | 1 | 5. Social Security N | n Square | | e (In yrs. las | t birthday) | If Under 1 | | If Under 2 | | 8. Date of Bir | th | <u>3alt</u> | 9. Birthp | lace (State or Foreign |
| | Director | | 220-30-63 | | □ M 2 X F | 76 | Yrs. | Months | Days | Hours | Min. | (Month, Da | r 8, | 1935 | Mary. | land |
| þ | show d at | 'n | Usual Residence | of Decedent 10b. County | | 10c. City, | Town or Lo | cation | | <u> </u> | | | | | 1 | 0d. Inside City Limits |
| Maryla | 28a-f s | Director | MD | Balti | moire | | Park | ville | | | | | | | | 1 🗌 Yes 2 🎞 No |
| th the | 3a or 3 | | 10e. Street and Nur | mber akewood R | 200 | | | 10f. Zip C | ode 21 2 | 234 | | | 10g. C | itizen of W | hat Coun USA | try? |
| ath wi | ems 2 r mus | Funeral | 11. Marital Status | akewood k | 12. Was Decedent | | 13. \ | Was Deceder | | | in? (Spe | cify Yes or No- Rican, etc.) | . | | | an Indian, |
| ffer de | ", or it | by | | ried 2 Married | Armed Forces? 1 Yes 2 If Yes, Give | | | f Yes, specify I □ Yes 2 | | | , Puerto | Hican, etc.) | | Black Specify: | k, White, 6 wh . | etc. ite |
| be filed within 72 hours after death with the Maryland | "natural", or items 23a or 28a-f s sdical Examiner must be notified | Completed | 3 Widowed | 15. Decedent's E | Year or Dates. | Т | 16a. Deced | dent's Usual (| Occupa | ation | | | 16b. l | Kind of Bu | siness/Inc | dustry |
| 1 27 ri | e. han "n e Med | omp | (Spe | ecify only highest gr ondary (0-12) | ade completed) College (1-4 or | 5+) | life. D | kind of work of NOT use re | etired) | | of work | ng | Sei | lf Em | vo fa | ed |
| y be | Hygien other to ont, the | Be C | 12 17. Father's Name | (First, Middle, Last) | 4 | | Tax | Prepa | Ter | | r's Nam | e (First, Middle | | | | |
| he file | rked c | 10 | | G. Mayr | | | | | | | | Weaver | , | | | |
| 2 should | and N is ma | d y | | ame/Relationship (7 | | | 19b. Mailir | ng Address (S | Street a | and Number | r or Rure | Route Number | er, City o | r Town, St | tate, Zip C | Code) |
| ביים ביים | Health tem 27 ther to | | 20a. Method of Dis | Eckhardt | spouse | 20b. Pla | no of Dieno | eition (Name | of | - | | Data | | _ocation - | | |
| Page 1 | ent of nt: If it ny or o | | 1 🔀 Burial 2 | | Removal from State | Sac | metery, crer red He | natory or other | er plac f J e | ej Esus F | eb.2 | 22,2012 | | | - | yland |
| ymit 8 | Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. | | | uneral Service Licen | | | Cemetro 22 FX | | Addres | ss of Facility | hane | l and (arkvil | Crem | ation | Ser | vices |
| | | | 23a Part 1 Enter | the disease or com | TVE + transplications that cause | d the death. | 88 | er the mode | rfo. | rd Ro | ad-I | arkvil. or respiratory a | le,M | aryla | and 2 | 21234 Approximate |
| - Pł | ı, sician/ | | shock, or hea Immediate Cause | art failure. List only o (Final | one cau on each lir | ie. | | | 20 | 0 00 | + | | | | | Interval Between Onset and Death |
| | Medical xaminer | | disease or condition resulting in death) | | a. Due to (or as | a c nseque | | LEY! | 11 | 100 | 1 | 0 | | | _ | |
| | xamme | er | Sequentially list co if any, leading to in cause. Enter Unde | onditions, | b. Due to (or as | nsl. | ve I | 11et | 25 | ta | +10 | : Car | cer | 2 | | |
| patr | d ansit | Examiner | cause. Enter Under Cause (Disease or that initiated even | rinjury | c | , | , | | | | | | | | | |
| executed | | I — I | resulting in death) | | Due to (or as | a conseque | ence of): | | | | | | | | | |
| Sate be | physic s the b | edic | | • | d | | | | | | | | | | | |
| Sertific S | ed by the attending physician detached for use as the buria | Physician/Medica | IF FEMALE: 23b. Was deceden | | 23c. If yes, outcome | | | ☐ Ectopic pre | eananc | cv | | | - 1 | | e of deliv | |
| death | he atte | /sici | in the past 12 1 ☐ Yes 2 9 ☐ Unknowr | ☑ No | 4 Pregnant 9 Unknown | at time of de | | Other (spe | | -1 | | | | Moi | nth | Day Year |
| that the | ed by detac | | | | contributing to death | but not resu | Iting in the I | ınderlying ca | use giv | ven in Part I | 1. | 23e. Did | tobacco | use contr | ibute to th | ne cause of death? |
| Luires t | been signe should be | ed by | Septi | c Shoc | K | | | | | | | 1 🗆 | Yes 2 | 2 🗆 No | 3 Pro | bably 4 Lunknown |
| | as bee | Completed | Diab | etes | | | | | | | | | s an opsy formed? | P | Vere auto prior to co death? | psy findings available impletion of cause of |
| The The | icate h | | 25. Was case refer | red to medical | | | | | oe D | lane of Door | th (Chao | 1 Yes | | | Yes | 2 No |
| Vsiciar | s certil directo | To Be | examiner? | No | Hospital: | tient 2 🗆 E | R/Outpatie | nt 3 🗆 DOA | Oak | lace of Deat er: 4 🗌 Nu | | ome 5 \square Res | sidence | 6 Othe | er (Specify | () |
| 5 8 | fter thi | | 27. Manner of Dea 1 Natural | th 5 Pending | 28a. Date of in (Month, D | | 28b. Time o injury | f 280 | c. Injur work | ζ? | | 28d. Describe | how inju | ury occurre | ed | |
| ottendi | death ctor: A y the f | Certificate: | 2 Accident 3 Suicide | Investigation 6 Could not | be 280 Place of Ir | ijury - At hor | ne, farm, str | meet, factory, | | Yes 2 | No | 28f. Location | (Street a | nd Numbe | er or Rura | I Route Number, |
| | s after al Dire ed in b | Cel | 4 Homicide | determined | | tc. (Specify) | | | | | | City or To | wn, Stat | te) | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be | within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical | 29a. Certifier (Check | 2 Medical Evan | ysician: To the best on the basis of | examination | and/or inves | stigation, in m | v opinia | on, death oc | ccurred a | t the time, date | and plac | ce, and due | e to the ca | use(s) and manner stated |
| o the | vithin 2 | Ž | only one) 29b. Signature and | | rse Practitioner: To | he best of m | y knowledge | | | the time, dat e number | te and pi | ace, and due to | | ate signed | | |
| | 71-0 | | 1 | / | 12 | | | RI | ES | 500 | ∞ |) | 02 | 2-1 | 8- | 2012 |
| | | | 30. Name and add | 1 / 2 | completed sause of | death (Item | 23a) (Type, | Print) | 4.0 | . 00: | 10 | 2-11 | | | 200 | 21227 |
| | Sta | te | 31. Date filed (Mor | | 32 Regis | rar's Signati | | n oqu | UK | - UKI | VE ; | DUT | MAC | JKC; | כנוייו | 21237 |
| | Pogietr | | 1 | EED 0 1 2 | 117 AL | . 4 | 9 16 | 2 Kel | | | | | | | | |

DHMH 17 Rev 06-2011

DHMH 17 Rev 06-2011

State Registrar

within 2

(Check

only one 29b. Signature

31. Date filed (Month, Day,

of person who completed cause of death (Item 23a) (Type, Print)

tow

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Mays

29d. Date signed (Month, Day,

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Lynn

29c. License number

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 04802 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Louisa Catherine Elgert February 17 2012 Year 11:14 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 2816 Munster Road Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 1 M 2 X F December 23 Marviland 213-10-3286 1914 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2816 Munster Road 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Yes 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) ellmann 18. Mother's Name (First, Middle, Maiden Surname) George Washington Bellman Sophia Sauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2816 Munster Road Baltimore Maryland 21234 Nancy Ford/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oaklawn Cemetery 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 2/22/12 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Euneral Service License ²² Name and Address of Facility Inc. Leonard J. Ruck, Inc. 5305 Harford Road Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line 26 dominal assess Immediate Cause (Final disease or condition

Physician/ Medical Examiner

Department of H Important: If ite any injury or ot

Physician/

Medical

Director

Completed by Funeral

Be

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Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f sho Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

if Health and Mental Hyglene.
item 27 is marked other than "natur other traumatic event, the Medical I

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran physician and Division of Vital Records, P.O. Box 68760 e has I een signed by ge 2 should be detach has h ğ funeral director,

After this

24 hours after death Funeral Director: filled in by the

within 24 hor To the Fune completed fi

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State

Registrar

Be Completed by Physician/Medical Examiner Medical Certificate: To

| resulting in death) | Due to (or as a consequence of): | w | | |
|--|---|---------------------------------------|--|---|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury | b. Due to (or as a consequence of); | | | |
| that initiated events resulting in death) Last | c | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | ctopic pregnancy ther (specify) | | 23d. Date of delivery Month Day Year |
| Part II. Other significant conditions Dementia, | contributing to death but not resulting in the under CHF, Chronic rene server struck februal also | orlying cause given in Part I. | | o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☒ Unknown |
| Anemia | strak februal also | in | 24a. Was an autopsy performed 1 Yes 2 | |
| 25. Was case referred to medical | | 26. Place of Death (Chec | ck only one) | |
| examiner? 1 ☐ Yes 2 ☐ 🌠 o | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 | Other: 4 Nursing H | ome 5 Residence | 6 ☐ Other (Specify) |
| 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation | 30() | 28c. Injury at work? M 1 Yes 2 No | 28d. Describe how in | jury occurred |
| 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined | | factory, office | 28f. Location (Street City or Town, Sta | and Number or Rural Route Number, ate) |
| (Check 2 Medical Exar | hysician: To the best of my knowledge, death occi miner: On the basis of examination and/or investigat urse Practioner: To the best of my knowledge, deat | tion, in my opinion, death occurred a | at the time, date and pla | ace, and due to the cause(s) and manner stated. |
| 29b. Signature and title of certifier | | 29c. License number | 29d. | Date signed (Month, Day, Year) |

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2/18/2012

21204

32. Registrar's Signature

seorge Karkar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles 5:

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FEB 21

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February IT, 2012 6:25 ам Willie Earl Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Olney Montgomery General Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Sept. 12, 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Country) Director 78 SC 247-46-1078 Sept. Usual Residence of Decedent shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2x No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3227 BelPre Road 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc þ 1 X Never Married 2 Married 1 Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify African-1 Yes 2 X No Specify: 3 Divorced "natural" Completed Year or Dates American Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Distribution Warehouse Worker unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ unknown unknown 19a. Informant's Name/Relationship (Type, Print) PG . County 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Mason/Guardian Spec 6420 Allentown Road, Camp Springs, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) West Arundel Crem. 2012 Odenton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Ken Skile 313 Talbott Ave., Laurel, M01053 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy perform Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending Accident
Sulcide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Raphael Gaston Loutoby, MD, 18101 Prince Philip Dr., Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one

29b. Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month izabeth FORD 2:42 AM Medical FEBRUARY 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore washington Medical Center 301 Hospitalds, Glen Burnie Anne Arund 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 👿 F Months Director MARUJAND show 10c. City, Town or Location must be notified at 10d. Inside City Limits Director PASAdeNA 28a-f ANN ARUNDAL 1 🗆 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 21122 BEALES U.S.A 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: BLACK Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) House Keeper HOME MAKER marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ *William* FORD JUANITA TURNER and l 19a. Informant's Name/Relationship (Type, Print) Jet 1 and 2 s.

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Important: If item 27 in

y injury or off-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2112 & LAVERNE FURD PASAdeNA, MARYIANA TRAIL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State LANSdOWNE, MARY IAND 4 Donation 5 Other (Specify) 2012 permit.
Departm
Importa
any inju 21. Signature of Funeral Service Nicensee 22. Name and Address of Facility Re DERRICK C. JONES FIH, P.A BAITIMURE, MARVIAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Physician/ Onset and Death 51-7355 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** AsillAsim PNILLMONM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 9 Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No After this certificate 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending nours after death neral Director: A ifilled in by the fu ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ft.

in 24 hour.

o the Funeral Dr

completed filler' Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of centifier 29d. Date signed (Month, Day, Year) 0053707 FEBRUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLYNK BALTIMONAL misi Coz いかられたいか 31. Date filed (Month, Day, Day, Year) State 2 1 2012 Registrar

DHMH 17 Rev 7/2009

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February 19, 2012 **Physician** JOHN FRANCIS FOLDERAUER 9:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Transitions Hospice Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ▼ M 2 □ F 215-28-2684 81 Maryland Nov. 17, 1930 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at Sykesville 1 ☐ Yes 2 🗓 No Director Maryland Carrol1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3805 Robin Hood Way 21784 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Korea 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 █No Specify Specify: White 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Westinghouse Corp. Quality Control Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Frank Folderauer Bernadine B. Kloyd ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arline G. Folderauer if item 27 is 3805 Robin Hood Way, Sykesville, Maryland 21784 (Wife) Department of Health Important: If item 27 any Injury or other trong. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory, Inc. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/23/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-POlyniak Funeral Hone, P.A. 21. Signature of Funeral Service Licensee Kevin E Fcker M00175 130 East Fort Avenue, Baltimore, Md. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MALIGNANT LYMPHOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician Physician/Medical as the for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes director. 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760, To the I within 2

altimore, Maryland 21215-0036

State

LEONARD 31. Date filed (Month, Day, Year) FEB 2 1 2012

29b. Signature and title of certifier

29a. Certifier

RICHARDSON M.D. 1838 GREENE TREE ROAD # 300 PIKESVILLE MD 32. Registrar's Signature

M-D

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number DS7722 29d. Date signed (Month, Day, Year)

FEBRUARY 20 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY Day 5 2012 5:12P Physician/ Regina Josephine Scheiner Frames Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON 9. Birthplace (State or Foreign County) aryland 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth **Funeral** 1 🗆 M 2 🗆 F (MO9/01/1942 215-42-0929 69 **Director** Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No Towson Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 USA 240 Linden Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc. ò 1 Never Married 2 Married Maryland 21**2**15-0036 1 ☐ Yes 2X No Specify If Yes, Give Specify: Completed 3 Widowed 4X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teller Trainer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Josephine Stehlik Joseph E. Scheiner, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diana Frames Buckland / Daughter 206 Duke Of Kent Ct., Apt., 201, Cockeysville, MD 21030 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗌 Burial 🏻 2 Cremation 3 🗀 Removal from State 2/20/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO BOX 1413Baltimore, MD 21203 Dorota Marshall 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ : lostridium disease or condition 4 daws Medical resulting in death) Due to (or as a consequence of): Examiner month ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner executed use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last been signed by the attending physician and Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Year should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à emphysema 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 1 Yes 2 No this certificate completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Certificate: To 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After work?
1 \(\sum \) Yes 2 \(\sum \) No 5 \square Pending 1 Natural Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: It is the state of my knowledge of the country in the cause of (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar Movie Chillin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

D 20907

N Charles St. B. Himore, Md

2/16/20/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Paul Michael Friedlander Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEDICAL W501 0 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Months 218-32-6915 **Director** 1 M 2 🗆 F 74 1937 Maryland April 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Medical Examiner must be notified at Director 1 Yes 2 X No York New Freedom PA. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 0 Funeral **USA** 17349 items 23a 10 Ashlee Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc or 1 Never Married 2 X Married Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: If Yes, Give Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Medical Pharmacist other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, and Mental Fisher is marked of t. Page 1 and 2 should be fill thent of Health and Mental rant: If item 27 is marked မ J. Leon Friedlander Mildred Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 Ashlee Court New Freedom, PA. 17349 Karen Friedlander/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Department of Important: If any injury or 2-22-12 Timonium, MD. Dulaney Valley Mem. 21. Signature of meral Service Livensee 22. Name and Address of Facility on Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine should be detached for use as the burial-transit and Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed 1 🗌 Yes 2 🗆 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Tyes Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: 6 🗌 Suicide Could not be . Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 3 [only one 29b. Signature and title of ce

State Registrar 30. Name and address of person who completed cau

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32. Registrar's

DHMH 17 Rev 06-2011

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OSLER PRIVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ 6:32A Richard A. Ford Feb 18 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Hospice Dove House Westminster 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 6-17-1928 1 **X** M 2 □ F 218-22-5418 83 MD Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a. State with the Maryland Director Westminster Carroll 1 Yes 2 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 441 Bankard Rd. 21158 death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 XYes 2 □ No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Military Armed Forces 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eleanor V. Harrison Dakay W. Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 441 Bankard Rd., Westminster, MD 21158 Lois E. Ford-wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) South Carroll Crem 2-20-12 Sykesville, MD 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Juneral Service Licensee 254 E. Main St., Westminster, MD 21157 homas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician 4091 disease or condition Medical resulting in death) as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE nse yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month ģ Pregnant at time of death 2 🗌 No been signed by the sahould be detached g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 performed 1 Yes 2 No Yes 2 N 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Pother (Specify) မ 1 Inpatient 2 Inpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar

State

who contpleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (Firet, Minute, Last) 2. Date of Death Gerald Gary Grimm Physician/ February **20**^{ay} 2012^{ea} 2:34 A. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore County 4b. City, Town, or Location of Death Examiner Towson Gilchrist Hospice Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year)
April 4, 1952 Country)
Pennsylvania 219-58-5818 Days 59 Director 1¥ M 2 □ F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural". 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Jarrettsville 1 ☐ Yes 2 No Maryland Harford County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4157 Madonna Roed 21084 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black White etc. 1 Never Married 2 X Married Completed by Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ Constellation Energy Gas Planning Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Arlene Grace Kuntz Benton H. Grimm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4157 Madonna Road, Jarrettsville, Maryland 21084 Deborah Grimm (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Feb. 25,2012 Fallston, Maryland Highview Memorial Cons. Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility. Evans Funeral Chapel & Cremation Services — I 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician ancient disease or condition resulting in death) Medical Die to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has b autopsy performed? Yes 2 **Director:** After this certificate of in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 유 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical 29a Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Centifying Nurse Practitioner. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check

Registrar DHMH 17 Rev 06-2011

State

29b. Signature

ARRON

31. Date filed (Month, Day, Year)

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MM

29c. License number

J. Charkes ST

29d. Date signed (Month, Day, Year)

2012

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marv Η. Grimm 2012 9:05 A M February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Nursing Center Chevy Chase Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** (Month, Day, Year) aug. 24,1922 Days Min. Director 216-46-2582 1 🗆 M 2 🗶 F 89 Aug. Connecticut Usual Residence of Decedent 28a-f shov 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location Director MDMontgomery Kensington 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3821 Lawrence Ave. United States 20895 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. "natural", Specify: White 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) the 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental i မ Archibald MacLeish Ada T. Hitchcock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Mina Erickson / Daughter 13104 Jingle Lane, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State of 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or Chesapeake Crematory 02/18/2012 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD V 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** INANITION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir or Attending Physician: The law requires that the death certificate be executed ician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Unknown g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2XXNo 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death? autopsy 2 No Yes Yes 2 X No 25. Was case referred to medical the funeral director 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 X No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 XX Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending ours after death.

leral Director: Af

filled in by the fu 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Funeral Medical 🕮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) ant title of certifie 29c. License number 29d. Date signed (Month, Day, Year, D37142 February 17, 2012 30. Name and address of person who co mpleted cause of death (Item 23a) (Type, Print) 1355 PICCARD DR. # 100, ROCKVILLE, MD 20850 GEOFFREY COLEMAN M.D., 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

| | | - | For State Registrar | State of Mai | ryland | • | tificate of D | | | Reg. No. | 012 | 04811 | |
|-------------------------------------|---|-------------|---|---|---------------|-------------------------|---|---|---------------------------------|---------------|--------------------------------|--|--|
| П | Physicia | n/° | 1. Decedent's Name (First, Middle, La | • | | | | | 2. Date of Dea | Dav | Year | 3. Time of Death | |
| | Medic | al | A. F. W. Alexandra (Contains a linear and a | Akram G | Gill | | | Lead of Death | Februa | ry 18, | 2012 | 8:45 P M | |
| | Examin | er | 4a. Facility Name (if not institution, given 13270 Highland F | | | | 4b. City, Town, or Highland | | | | unty of Death 7ard | | |
| | Funeral | | 5. Social Security Number 6. S | Sex 7. Age (| In yrs. last | birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt | h | g. Birth | place (State or Foreign | |
| | Director | | 216-13-8805 | X M 2 □ F 8 | 1 | Yrs. | IVIONILIIS Days | Hours Will. | oct 10 | 1930 | Pak | istan istan | |
| | at at | ō | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, To | own or Loc | ation | | | | 1 | 10d. Inside City Limits | |
| | Maryla 8a-f s tified | Director | MD Howard | | High | land | | | | | | 1 Yes 2 □ No | |
| | a or 2 be no | io le | 10e. Street and Number | | | | 10f. Zip Code | _ | | 10g. Citizen | of What Coul | ntry? | |
| | th with ms 23 must | Funeral | 13270 Highland F | | | | 20777 | | * N N | Pakis | | | |
| ~ | or iter | by Fu | 11. Marital Status1 ☐ Never Married 2 ☐ Married | 12. Was Decedent Even Armed Forces? 1 Yes 2 X N | er in U.S. | 13. V | Vas Decedent of His Yes, specify Cubar | spanic Origin? (Spe n, Mexican, Puerto | Rican, etc.) | | Race - Amerio Black, White, | | |
| 8 | rs afte Iral", | ed b | 3 ☑ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates. | | 1 | ☐ Yes 2 🛛 No | Specify: | | Spe | cify:Sout | h Asian | |
| 2-0 | 2 hou "natu edical | Completed | 15. Decedent's l (Specify only highest g | | 1 | (Give k | ent's Usual Occupa ind of work done d | | ing | 16b. Kind | of Business In | dustry | |
| 121 | ithin 7 ene. r than | Com | Elementary/Seconday (0-12) | College (1-4 or 5+) | | life. DC Mecha: | NOT use retired) | | | Manuf | acturi | na | |
| d 2 | iled w I Hygi othel rent, 1 | Be | 17. Father's Name (First, Middle, Last) | | | icona | | 18. Mother's Name | e (First, Middle, | | | | |
| /lar | d be f Menta arked | 욘 | Faqirchand Gill | | | | | Hussain | Bibi | | | | |
| lar. | shoul | | 19a. Informant's Name/Relationship (| | Į. | | , | | | | City or Town, State, Zip Code) | | |
| e, N | and 2 Health em 27 ther t | | Zafar Gill / sor | 1 | 20h Plac | | 0 Highlar sition (Name of | - | Highlan Date | | y Land ion - City or To | | |
| nor | age 1 ent of it: If it y or o | | 1 X Burial 2 Cremation 3 4 Donation 5 Dother (Spec | Removal from State | cem | etery, crem | natory or other place s Cemeter | 9) | 22, 12 | | - | e, Maryland | |
| Baltimore, Maryland 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signat of Funeral Service Licer | - | St. | | Name and Addres | | | | SVIIIC | Flatytand | |
| Ä | Depar Impo any ir | | What He | ll. | aurei, | .A. Maryla | and 207 | 707-4389 | | | | | |
| | | | 23a. Part 1. Enter the disease, or con shock, or heart failule. List only | one cause on each line | | | | | | rest, | | Approximate Interval Between | |
| with the | Medical | (i) 8 | Immediate Cause (Final disease or condition resulting in death) | a. Ke. | Spir | rato | ry Di | stres | ٢ | | | Onset and Death | |
| | Examiner | | | Due to (or as a | uke | ce ot): Mic7 | _ | | | | | loyears | |
| | | iner | sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a | | | | | | | | 9 - 7 - | |
| | cuted ind transit | Examiner | Cause (Disease or iinjury that initiated events | c | | | | | | <u> </u> | | | |
| | cate be executed physician and s the burial-transit | alE | resulting in death) Last | Due to (or as a | consequen | ce oi). | | | | | | | |
| 68760 | icate l | ledical | | d | | | | | | | | | |
| 89 x | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/M | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of | | | Ectopic pregnanc | у | | 230 | . Date of deliv | | |
| B 0 | death the att | ysici | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 Pregnant at t | | | Other (specify) | | | | Month | Day Year | |
| Ö. | at the | | Part II. Other significant conditions | contributing to death but | t not resulti | ng in the u | nderlying cause giv | en in Part I. | 23e. Did to | obacco use | contribute to t | he cause of death? | |
| S, F | uires t n sign | ed by | Chroni | c kidne | 1 2 | disea | 35C | | 1 🗆 | Yes 2 🔀 | No 3 🗆 Pro | bably 4 🗆 Unknown | |
| örc | w require ts been si 2 should b | Completed | Anemic | 7 | | | | | 24a. Was | | 4b. Were auto | ppsy findings available empletion of cause of | |
| Rec | sician: The law scrifficate has k | Som | | | | | | | | rmed? | death? | | |
| ta | ician: certific ector, | Be | 25. Was case referred to medical examiner? | Hospital: | | | 26. Pla | ace of Death (Chec | | | | | |
| Į V | Physical direction | <u>ان</u> | 1 Yes 2 XNo 27. Manner of Death | 1 Inpatier | | NOutpatien Bb. Time of | t 3 DOA 28c. Injury | 4 LJ Nursing Ho | ome 5 KResio 28d. Describe I | | | ·y) | |
| ว น | Attending Physician: The le er death. ector: After this certificate he by the funeral director, page | icate | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation | (Month, Day, | Year) | injury | work' | | 204. 2000/1501 | ion injury oc | 041104 | | |
| Division of Vital Records, P.O. Box | I or Atten after deat Director: I in by the | Certificate | 3 Suicide 6 Could not 4 Homicide determined | | | e, farm, stre | eet, factory, office | | 28f. Location (S | | mber or Rura | il Route Number, | |
| Ö | oital o | | N | | | | L Market | lete en la face en | | | | | |
| | To the Hospital or / within 24 hours after To the Funeral Dire completed filled in bire | Medical | (Check 2 Medical Exam | ysician: To the best of m niner: On the basis of exa rse Practioner: To the b | amination ar | nd/or invest | igation, in my opinio | n, death occurred a | t the time, date a | and place, an | d due to the ca | ause(s) and manner stated. | |
| | To the within To the comp | 2 | 29b. Signature and title of certifier | | | | 29c. License | number | | 29d. Date si | gned (Month, | Day, Year) | |
| | 1 | | Straunt | Killon | W2 | | DO | 05886 | 0 | 1-6 | 26 ZO | ,2012 | |
| í | | | 30. Name and address of person who | completed cause of dea | ath (Item 23 | 33 (Type, P | rint) 3 N. CAL | VERZT S | T. 501 | tess | S BA | LTO MD | |
| | Stat | e | 31. Date filed (Month, Day, Year) | 32 Registrar | Signature | - A | house | / | | | | 21218 | |
| | Registra | ar | | | | | | | | | | | |

| | | | For State Registrar | State of Mary | | - | artment o <i>tificate o</i> | | | | giene Reg. Na | 20 | 2 | 04813 | 2 |
|------------|---|------------------|--|---|-----------------|---------|---|-------------|-----------------------------|--|------------------|-------------------------------|---------------------|---------------------------------|----|
| | Physicia | n/ | Decedent's Name (First, Middle, Last | Annie R. Gar | dner | | | | | 2. Date of Dea Month February | ath | | ear | 3. Time of Death 12:01 A M | |
| - } | Medic Examin | | 4a. Facility Name (if not institution, give | street and number) | | | 4b. City, Towr | n, or Loca | tion of Death | repruary | \neg | . County of | | µ∠:ОГА ™ | _ |
| | Formarial | | Gilchrist Hospice 5. Social Security Number 6. Se | x 7 Age (In | yrs. last birth | dav) | Towson | | nder 24 Hrs. | 8, Date of Birt | <u> </u> | Balti | | lace (State or Foreign | _ |
| | Funeral Director | | 217-05-7044 | ^ 2XXF 94 | | rs. | Months Da | | | Jan 8, 19 | / Yearl | | Count | ry) | |
| | and show | tor | Usual Residence of Decedent 10a. State 10b. County | | c. City, Town | or Loc | cation | | | | | | 1 | Od. Inside City Limits | _ |
| | Maryl 28a-f notified | irect | MD N/A | | Balt | imoı | ., | _ | | | | | \perp | 1XXX Yes 2 ☐ No | _ |
| | vith the 23a or st be r | Funeral Director | 10e. Street and Number 2211 West Rogers Aven | ue | | | 10f. Zip Cod | | | | 10g. Ci | tizen of Wha | at Coun | try? | |
| | s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | | 11. Marital Status | 12. Was Decedent Ever Armed Forces? | in U.S. | 13. V | | of Hispanio | c Origin? (Spexican, Puerto | ecify Yes or No- Rican, etc.) | | 14. Race - | America White, e | | _ |
| 0500-c1 | filed within 72 hours after al Hygiene. d other than "natural", or vent, the Medical Exami | ed by | 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced | 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates. | | 1 | ☐ Yes 2XX | (No Spe | ecify: | | | Specify: W | | | |
| 2-0 | 72 hou n "natu Aedica | Completed | 15. Decedent's Ec (Specify only highest gra | de completed) | (| Give k | lent's Usual Oc kind of work do O NOT use retir | ne dunna | most of work | ing | 16b. K | (ind of Busi | ness/Inc | lustry | |
| 717 | led within 7: Hygiene. other than ent, the Me | | Elementary/Secondary (0-12) 9th | College (1-4 or 5+) | _ | lerk | | | | | M | arylan | d Cas | sualty | |
| yland | l be filed with lental Hygien rked other tl tic event, the | To Be | 17. Father's Name (First, Middle, Last) James Eugene VanStavo | oren | | | | | Mother's Nam attie Ha | e (First, Middle, | Maiden | Surname) | | | |
| Mary | should be file and Mental 7 is marked or raumatic eve | | 19a. Informant's Name/Relationship (Ty | | 19b. | Mailin | g Address (Stre | | | al Route Numbe | ; City oi | Town, Stat | e, Zip C | ode) | |
| e, | and 2 s Health em 27 ther tra | | Van H. Gardner (Son | | | | | | 1 | more, MD | | | | | |
| saltimore, | Page 1 nent of I int: If its | | 1 XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | Removal from State | cemetery | , crem | sition (Name of natory or other Lley Memo | place) | 2/22/ | Date 12 | | ocation - Ci monium | 1 | wn, State | |
| Balt | permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce. | | 21. Signature of Funeral Service License | 1 | | | Name and Ad | | acility Burg | gee Henss , MD 212 | Seit | z Funei | ral H | lome, Inc. | |
| Ħ | | | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or | lications that caused the | death. Do no | | | | | • | | | | Approximate Interval Between | |
| | nysician/ Medical | 3 3 | Immediate Cause (Final disease or condition resulting in death) | a OCIHE | | | Pailur | | | | | | | Onset and Death | |
| لحميد | Examiner | | | Due to (or as a co | nsequence of | f): | | | | | | | | | |
| _ | ed sit | Examiner | Sequentially list conditions, if any, leading to immediate | Due to (or as a co | nsequence of | f): | | | | | | | | _ | |
| 6 | execute an and rial-tran | Еха | that initiated events resulting in death) Last | c. Due to (or as a co | nsequence of | f): | | | | | | | + | | _ |
| 2 | cate be executed physician and s the burial-transit | edical | | d | | | | | | | | | + | | |
| ΩΩ × | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic. | | 20b. was decedent pregnant | 23c. If yes, outcome of p | | 3 🗆 | Ectopic pregr | nancy | | | | 23d. Date | | | |
| . box | he deatly the att | Physician/M | in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown | 4 Pregnant at tim 9 Unknown | e of death | 5 [| Other (specify | () | | | | Month | 1 | Day Year | |
| у. Э | es that t igned b be deta | | Part II. Other significant conditions co | | | | | | | 23e. Did to | | | | e cause of death? | |
| oras | requir been s should | letec | Chronic renal for Myspercalcemia | 1 20010 | 2000 | 700 | 14-007 | 101 · | 72(1 | 24a. Was | | 24b. We | re autop | sy findings available | _ |
| Records, | The law ate has page 2 | Completed by | 1.045 CHICKLING | OPEINIC | Chex | או על | Opur | 119 | | autop perfo 1 🗆 Yes | rmed? 2 XN | prid dea o 1 [| th? | npletion of cause of | |
| N Ea | sician: certific lirector, | Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | a □ ED/0.4 | | | | Death (Chec | k o <i>nly one)</i> ome 5 \square Resid | | N | | 1/2-01 6.0 | - |
| 5 | ng Phy fter this uneral c | ate: To | 27. Manner of Death Natural 5 Pending | 1 Inpatient 28a. Date of injury (Month, Day, Ye. | 28b. Ti | | 28c. lr | njury at | | 28d. Describe h | | | <u> Specity)</u> | 1020,C | _ |
| DIVISION | Attendi r death sctor: A by the f | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - | | m, stre | | Yes | 2 🗆 No | 28f. Location (S | treet an | d Number o | r Rural | Route Number, | _ |
| <u> </u> | ital or urs afte ral Dire | | | building, etc. (S | | | | | | City or Tow | | | | | |
| | n 24 ho n 24 ho le Fune | Medical | (Check 2 Medical Examir | ician: To the best of my I ner: On the basis of exami e Practitioner: To the be | ination and/or | invest | igation, in my o | pinion, dea | ath occurred a | t the time, date a | nd place | , and due to | the cau | se(s) and manner state | d. |
| | To the To the con | | 29b. Signature and title of certifier | , , | | | 29c. Lice | ense numt | ber | | 29d. Da | te si <i>g</i> ned (/\ | 10nth, E | ay, Year) | |
| | a | | 30. Name and address of person who co | ompleted cause of death | (Item 23a) (Ti | ype, P | rint) | 142 | 25C | [4 | rep | non | 11 | 419015 | _ |
| | V | | Relecce Situl | a 555 U | ten | 6 | wso | Hay | in B | ud To | كسا | en N | 2 | PO616 | _ |
| | Stat Registra | | 31. Date filed (Month, Day Year) FEB 2 1 | 2012 32. Registrar's S | Signature | 1 | backed | | | | | | | | |

28a-f show 72 hours after death with the Maryland 5 items 23a o Baltimore, Maryland 21215-0036 "natural", and Mental Hygiene. is marked other than Health tem 27 0659 5017 15, FBRUREV P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 6:59 AM Physician/ Fo briary William Ray Gavin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 519-38-2720 1 🙀 M 2 🗆 F Director September 15, 1937 74 Idaho Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director Rockville 1 X Yes 2 No Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 500 Azalea Drive 20850 United States Was Decedent Ever in U.S. unk
 413. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Medical Examiner rmed Forces?

X Yes 2 \(\subseteq \) No Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 5+ Systems Analyst Electronics Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Clamour Gavin LaVon Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Kring Gavin / wife 500 Azalea Drive, Rockville, Maryland 20850 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition February 20, Department of Important: If it any injury or o once, cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer nse an Death Immediate Cause (Final Physician/ DHIC disease or condition resulting in death) Medical a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examir attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be 2 No Other: 1 Yes ၉ 1 Manatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Occrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

State Registrar

SHADY GROVE RD ROCKVILLE MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15225

32 Registrar's Signatu

CHANALES

5-

State of Maryland / Department of Health and Mental Hygiene

| | | | _1 | State Registrar | | Cer | tificate of | Death | | Reç | J. No. | | | |
|-------------------------------------|--|-------------------|------------------|---|--|-----------------------|---|-------------------|---------------|---------------------------------------|-----------------|---------------|------------------------------|------------------|
| П | - | | , | 1. Decedent's Name (First, Middle, Las | t) | | | | | Date of Death Month | Day | Year | 3. Time of D | eath |
| | | sicia: ledic | _ | | Yuxiang Ga | in | | | | ebruary | | 2012 | 2:06 | \mathbf{A}^{M} |
| | | mine | | 4a. Facility Name (if not institution, give | street and number) | | 4b. City, Town, | or Location of | Death | | 4c. County | of Death | | |
| - | | | | | Hospital | | If I is along the second | Bethes | | D. L. (Dist | N | lontgo | | Favaion |
| | Fund | _ | | 5. Social Security Number 6. So | 7. Age (In yrs. la | ist birthday) | If Under 1 Year Months Days | | | Date of Birth (Month, Day, Ye | ear) | 9. Birting | olace (State or I try) | oreign |
| | Direc | tor | | 258-51-8620 Usual Residence of Decedent | ^M 2 □ F 70 | Yrs. | | | No | ov e mber 2 | 7, 1941 | C | hina | |
| | land | at | 5 | 10a. State 10b. County | 10c. City | , Town or Lo | cation | | | | | 1 | 0d. Inside City | Limits |
| | anyla | med | ect | Many land Mantaga | | | D | ethesda | | | | | 1 🗆 Yes 2 | 2 X № |
| | he M or 28 | e not | 늅 | Maryland Montgo 10e. Street and Number | mery | | 10f. Zip Code | ernesaa | 1 | 10 | g. Citizen of | What Cour | ntry? | |
| | with t | st b | Funeral Director | 7004 Will | son Lane | | | 20817 | | | Unit | ed St | tates | |
| | eath | ı ı | اج | 11. Marital Status | 12. Was Decedent Ever in U.S. | 13. | Was Decedent of | Hispanic Origi | n? (Specify | Yes or No- | 14. Rad | ce - Americ | an Indian, | |
| 9 | ter d | imin | ğ | 1 Never Married 2 X Married | Armed Forces? 1 ☐ Yes 2 X No If Yes, Give | 1 | 1 ☐ Yes 2 🛣 N | | T donto The | ari, oto., | Specify | ck, White, | atc. | |
| 800 | urs at | al Ex | ted | 3 Widowed 4 Divorced | Year or Dates. | | | | | | | As: | <u>ian</u> | |
| 21215-0036 | "nat | edica | Completed | 15. Decedent's E (Specify only highest gra | | (Give | dent's Usual Occu kind of work done O NOT use retired | during most of | of working | 11 | 6b. Kind of E | Jusiness/In | dustry | |
| 12 | thin 7 | De M | 点 | Elementary/Secondary (0-12) | College (1-4 or 5+) | | io-Chemi | , | | | Feders | 1 Go | vernmen | ₊ |
| 2 | ed wi Hygie | ent, t | a) l | 17. Father's Name (First, Middle, Last) | <u>5</u> + | | IO OHCIMI | | 's Name (Fi | irst, Middle, Ma | | | /CI IIIICII | _ |
| an | be fill ental ked | c eve | P | | Yi Gan | | | | C | ui-Zher | Chen | | | |
| Maryland | ould nd Me | ımatı | | 19a. Informant's Name/Relationship (7 | | 19b. Maili | ng Address (Stree | t and Number | | | | State, Zip (| Code) | |
| Š | ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho | r tra | | Bin Gan / So | nn | | Wilson | | | | | | | |
| Ē, | 1 and if Hea | othe | | 20a. Method of Disposition | 20b. P | ace of Dispo | osition (Name of matory or other pl | | bruar | 2 | 0c. Location | | | |
| Baltimore, | Page 1 ment of ant: If it | ry or | | 1 Burial 2 X Cremation 3 4 Donation 5 Other (Special | Removal Irom State | * | Crematori | | 2012 | | etheso | la. M | aryland | |
| alti | permit. Page Department o Important: If | any inju once. | | 21. Signature of Funeral Service Licen | | | Name and Add | | Emera | | | | | |
| m | De E | an | _ i | John Th | M0136 | 0 75 | 557 Wiscon | sin Aven | ue, Be | thesda, M | <u>farylanc</u> | 20814 | -3501 | |
| | | | | 23a. Part 1. Enter the disease, or com shock, or heart failure. List only of | plications that caused the deatl | n. Do not ent | er the mode of dy | ing, such as c | ardiac or re | espiratory arrest | ., | | Approximate Interval Betw | een |
| أغمر | Physici | ian/ | | Immediate Cause (Final disease or condition | | anial | Hemorrh | are No | n Trai | umatic | | | Onset and De 2 Days | eath |
| | Med | - 60 | | resulting in death) | a. Due to (or as a consequ | | Hemorri | age no. | | umu u u | | | | |
| | Exam | | . I | Sequentially list conditions, | h. | | | | | | | _ | | |
| | | | ine | if any, leading to immediate cause. Enter Underlying | Due to (or as a consequ | uence of): | | | | | | 25 | | |
| | cutec | trans | хап | Cause (Disease or injury that initiated events | cDue to (or as a consequ | inner off: | | | | | | | | |
| | ath certificate be executed attending physician and | urial | Medical Examiner | resulting in death) Last | Due to (or as a consequ | ierice oij. | | | | | | | | |
| 8760 | ate be | the b | dic | | d | | | | | · · · · · · · · · · · · · · · · · · · | | | | |
| 687 | artific. | | - | IF FEMALE: | 23c. If yes, outcome of pregna | ncv | | | | | 224 D | ate of deliv | /on/ | |
| X | ath ce | tor u | cian | 23b. Was decedent pregnant in the past 12 months? | 1 Live Birth 2 Feta 4 Pregnant at time of o | al death 3 | ☐ Ectopic pregna☐ Other (specify) | | | | | lonth | | ear |
| Ď. | requires that the death cel | ched ' | Physician, | 1 Yes 2 No 9 Unknown | 9 Unknown | | | | | | | | | |
| 0 | hat the | detac | | Part II. Other significant conditions of | ontributing to death but not res | ulting in the | underlying cause | given in Part I. | | 23e. Did toba | icco use cor | tribute to t | he cause of de | ath? |
| S, | ires t | S P | q p | Hypertension | | | | | | 1 🗆 Yes | 2 🗆 No | 3 🗌 Pro | bably 4 🗓 U | nknown |
| ord | requ | Exminury | Completed by | | | | | | | 24a. Was an | | . Were auto | opsy findings av | vailable |
| ec | e has | age 2 | шc | | - | | | | | autopsy perform | ed? | death? | | use of |
| <u>=</u> | in: Tr | ö. | Be C | 25. Was case referred to medical | | | 26. | Place of Death | h (Check or | | A. NO | 1 - 100 | | |
| Vita | Physician: The law this certificate has | Galrect | To B | examiner? 1 X Yes 2 □ No | Hospital: 1 X Inpatient 2 | ER/Outpatie | ent 3 🗆 DOA O | ther: 4 🗌 Nur | rsing Home | 5 🗆 Residen | ce 6 🗆 Ot | her (Specif | y) | |
| of | g Ph | funeral | | 27. Manner of Death | 28a. Date of injury (Month, Day, Year) | 28b. Time o injury | | ury at ork? | 280 | d. Describe how | / injury occu | rred | | |
| on | eath. er; Aft | the fu | fica | 1 X Natural 5 Pending 2 Accident Investigatio | n | ,, | | Yes 2 | No | | | | | |
| Division of Vital Records, P.O. Box | r Atte ter de recto | | Certificate: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | | ome, farm, st | reet, factory, offic | е | 281 | f. Location (Stre City or Town, | | ber or Rura | l Route Numbe | ÷r, |
| ă | ital o ırs af ral Di | illed in by | a C | | | | | | | | | | | |
| | | | Medical | (Check 2 Medical Exam | vsician: To the best of my know iner: On the basis of examinatio | n and/or inves | stigation, in my opi | inion, death occ | curred at the | e time, date and | place, and d | ue to the ca | ause(s) and man | ner stated. |
| | the the | completely \$ { d | ž | only one) 3 Certifying Nur 29b. Signature and title of certifier | se Practitioner: To the best of r | ny knowledge | | at the time, date | e and place | | d. Date sign | | | |
| | 2 3 5 | 3,5 | | Designation and the original | | | | | 5 | | | | | |
| | 11 | 7 | | 30. Name and address of person who | completed cause of death /Item | 23a) (Type | Print) | D6591 | ٠ | F | entua | <u>1 y 13</u> | , 2012 | |
| | V 0, | X | | Chuanbo Zhang, M | | | | d, Bet | hesda | , Maryl | and 20 | 0814 | | |
| | | Stat | te | 31 Date filed (Month, Day, Year) | 32 Registrar's Signa | | | | | | | | | |
| | Do | aistr | | FEB 2 1 2012 | Lever B. | MEAN | | | | | | | | |

0206 am

02/13/2012

YUXIANG GAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 12:20 P M SOLOMON GOODMAN 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SUNRISE OF PIKESVILLE PIKESVILLE 6. Sex 1**XX**M 2 □ F **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours 0472471923 Director 215-28-4272 88 Usual Residence of Decedent 10a. State aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified YX Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1101 ST. PAUL STREET, APT. 1505 21202 USA ral", or items? Examiner mus . Page 1 and 2 should be filed within 72 hours after death a ment of health and Mental Hygiene.
tant! If item 27 is marked other than "natural", or items unry or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates. WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SALES AUTO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ GOODMAN JULIUS ELLA LOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE ZWEIG/DAUGHTER 6190 SATINWOOD DRIVE, COLUMBIA, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM : 02/20/2012 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenser SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ACUTE FENAL disease or condition Medical resulting in death) **Examiner** w/K Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed after death. the attending physician and hed for use as the burial-transit domina Due to (or as a consequence of) resulting in death) Last Physician/Medical MO CANCE Division of Vital Records, P.O. Box 68760 nse IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 N 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 2 No Hospital Other: ပ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA e Hospital or Attending Pt 24 hours after death.
e Funeral Director: After the leted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

12

only one)

address of person who completed cause of death (Item 23a) (Type, Print)

02111

Sunrise Nursing of Pikesville

Pikesville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04816 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 2012 10:07 РМ Audrey A. Goetze Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Blakehurst Baltimore Towson 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. (Month, Day, Year) 212-05-3545 **Director** 1 □ M 2 🕅 F 94 Yrs Apr. 21. Maryland Usual Residence of Decedent 28a-f show 10b. County with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1055 W. Joppa Road 21204 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 □ Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Home Maker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Spaulding Albert Audrey Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is Spaulding A. Goetze, Sr. / son 3900 E. Monument Street; Baltimore, MD 21205 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once, Druid Ridge Cemetery | 2/23/2012 Pikesville, MD 21. Signature of Funeral Service Log 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it is a list cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of for use as the bunial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 1 Yes 2 g Unknown Unknown P.O. by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 has certificate 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Hospital 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 125205 February 19, 2012

DHMH 17 Rev 06-2011

State

Registrar

16781

death (Item 23a) (Type, Print)

30. Name and address of person who completed cause

FEB

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N- Charles St. Balto. Md Z(20)

| State of Maryland / Department of Health and Mental Hygiene | | | | | | | | | | | | | | | | | |
|--|--|-----------------------|--|--|---|---------------------------------|------------------|---|------------------|---------------------------------------|--|---|---------------------------------------|--|-------------------|--|--|
| | | _ | State Registrar | | Certificate of Death | | | | | | Reg. No 2 0 | | | 048 | | | |
| | Physicia | n/ | Decedent's Name (First, Middle, Las | | | | | 2. Date of Death Month FEBRUARY 16, 20 | | | 3. Time of D | | | | | | |
| | Medic | al | JACOB | | | | FEBRUA | | | 012 10:25 P M | | | | | | | |
| | Examin | er | 4a. Facility Name (if not institution, give | | - | | ocation of | Death | | 4c. County | | | | | | | |
| 79-0 | Funeral | | LEVINDALE HEBR 5. Social Security Number 6. Se | st hirthday) | If Under | | MORE If Under 24 | 4 Hrs. | 8. Date of Birth | N/A Birth 9. Birthplace (State or Fo | | | | | | | |
| | Director | Tulleral 1 XI M 2 D F | | | | | | Months Days Hours | | | | 1 ^{Year)} 9 | | Country) MD | | | |
| | _ Mo | Funeral Director | Usual Residence of Decedent | ' | | | | | | | | | | | | | |
| | yland -f she ed at | | 10a. State 10b. County | | | Town or Loc | | | | | | | 1 | 0d. Inside City | | | |
| | e Mai r 28a notifi | Sire | MD N/A 10e. Street and Number | | В | ALTIMO | _ | 0 1 | | | | | | 1X Yes | 2 ∐ No | | |
| | within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho ; the Medical Examiner must be notified at | rall | | | // 0.0.1 | | 10f. Zip | | | | | | 0g. Citizen of What Country? | | | | |
| | ems arth w | nue | 6320 GREENSPRIN 11. Marital Status | GAVENUE, 12. Was Decedent E | | 13. V | Vas Decede | 2120 ent of His | | n? (Spec | ify Yes or No- | USA 14 Bac | ce - Americ | en Indian | | | |
| 9 | or it | by F | 1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give | | If | Yes, speci | fy Cuban, | , Mexican, I | Puerto F | lican, etc.) | | ck, White, | | | | |
| 8 | ırs afi ural", IExa | ed | 3 X Widowed 4 □ Divorced | 1 | I ☐ Yes 2 🛣 No Specify: | | | | | Specify: WHITE | | | | | | | |
| 2 | 2 hot "nat | To Be Completed | 15. Decedent's Ed (Specify only highest gra | | lent's Usual Occupation kind of work done during most of working | | | | | 16b. Kind of Business Industry | | | | | | | |
| 12 | thin 7 | | Elementary/Seconday (0-12) College (1-4 or 5+) 5+ SALES | | | | | | | | | COMMERCIAL LAUNDRY | | | | | |
| d 2 | Hygie Hygie other ent, ti | | 17. Father's Name (First, Middle, Last) | JΤ | | SAL | ies_ | | 18. Mother | 's Name | (First, Middle, N | | | LAUNDR | .I | | |
| Maryland 21215-0036 | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | | SAMUEL | GI | TOME | R | | | REBE | | (i mot, imagic, ii | rarderi Garriari | c) | HAFT | | | |
| ary | should and Me | | 19a. Informant's Name/Relationship (Ty | oe, Print) | | 19b. Mailin | g Address | (Street an | | | Route Number, | City or Town, | State, Zip C | | - 1 | | |
| Σ | and 2 s Health s tem 27 i | | SUZANNE OLESKER | /DAUGHTER | | 230 | 7 KEN | N OAK | ROAD |), B | ALTIMOR | E, MD | 21209 | 1 | | | |
| ore | 4. O 4- 1- | | 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ | Removal from State | | ace of Dispos | | | | D | ate | 20c. Location | - City or To | wn, State | | | |
| Ē | Page 1 tment of tant: If it jury or o | | 4 Donation 5 Other (Specifi |) | A A | metery crem RLTNGT MUNO C | EMETE | ERY | 102 | 2/19 | /2012 | | IMORE | | | | |
| Baltimore, | permit. Page Department Important: I any injury o | | 21. Signature of Funeral Service Licens | e | | | | | | | LEVINS | | | | | | |
| | | | 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 | | | | | | | | | | | | | | |
| | | | shock, or heart failure. List only one cause on each line. | | | | | | | | | | | Approximate Interval Betw Onset and De | | | |
| - | Medical | | disease or condition resulting in death) SUDDEN CARDIAC DEATH Due to (or as a consequence of): | | | | | | | | | | | 1 | | | |
| | Examiner | | | | | CARDI | OMYOP | РАТНҮ | , | | | | | | | | |
| | | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | | | | | | | |
| 10 | outed nd ransit | Examiner | Cause (Disease or linjury that initiated events | | RY DISEASE | | | | | | | | | | | | |
| F 09/89 | be executed sician and burial-transit | al E | resulting in death) Last | Due to (or as a | conseque | ence of): | | | | | | | | | | | |
| 9 | ate the | Physician/Medical | | d | | | | | | | | | | | | | |
| 189 | ath certifica attending p | | IF FEMALE: 23b. Was decedent pregnant | | | | | 201 0 | 6 . 1 . 15 | | | | | | | | |
| Box | of the last | iciar | in the past 12 months? | 1 Live Birth 2 4 Pregnant at | | | Ectopic pr | | | | | | 23d. Date of delivery Month Day Year | | | | |
| | 9 9 g | hysi | 9 Unknown | g 🗌 Unknown | | | | | | | | | | | | | |
| O. | that the | by P | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? | | | | | | |
| ds, | quires en sig | ted | | | | | | | | | | 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🔀 Unknown | | | | | |
| S | aw re as be 2 sho | ıple | | | | | | | | | 24a. Was ar autops | prior to completio | | | ailable use of | | |
| The is page had been as a second seco | | | | | | | | | | 1 Perform | performed? death? 1 Yes 2 No 1 Yes 2 No | | | | | | |
| ta | ician; sertific ector, | Certificate: To Be (| 25. Was case referred to medical examiner? | Hospital: | | | | T | e of Death | | | | | - | | | |
| > | Phys this ral dir | | 1 XYes 2 No | 1 _ Inpatie | | R/Outpatien | | A Other: | 44 Nurs | | ne 5 Reside | | | | | | |
| 0 | th. After funer | | 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation | (Month, Day, | Year) | injury | M 20 | work? | es 2□N | | 8d. Describe ho | w injury occuri | ea | | | | |
| <u> </u> | Atter | rtifi | 3 Suicide 6 Could not be | et, factory, | office | | 2 | 28f. Location (Street and Number or Rural Route Number, | | | | | | | | | |
| 2 | tal or safte | | 4 — Hornicide determined building, etc. (Specify) | | | | | | | | City or Town, State) | | | | | | |
| _ | of the Hospital or Attending Physician: within 24 hours after death and the funeral Director; After this certific completed filled in by the funeral director, | Medical | 29a. Certifier 1 X Certifying Phys (Check 2 Medical Examin | | | | | | | | | | | | ner stated | | |
| | To the P within 24 To the F complet | Me | only one) 3 Certifying Nurs | | | | eath occurr | ed at the t | time, date a | | , and due to the | cause(s) and m | anner as sta | ted. | | | |
| | 6 ≥ 6 0 | | 29b. Signature and title of certifier | PHYSIC | ٠, مــم | SI. | | DO06 | 4533 | | 2 | 9d. Date signe 02/20 | | | | | |
| | .5 | | 30. Name and address of saves with | 1 1 1 | | | | | | T1 | MD T C C | - | 0/2012 | | | | |
| | 10 | | 30. Name and address of person who c | | | | | | | | | | 15 | | | | |
| | Stat | e | 31. Date filed (Month, Day, Year) | 32. Sictra | | re | | | CLI 9 D | ALL. | LIURE 1 | 10 212 | 1.0 | | | | |
| | Registra | | FEB 2 1 20 | 12 / Dage | 4 | ho | ales | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ John Christian Heil, Sr 40 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale FRANKLIN SQUARE Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. April 19,1919 217-05-6275 **Director** 1 🕅 2 🗆 F Maryland 92 Yrs. Usual Residence of Decedent 28a-f show ıral", or items 23a or 28a-f sho I Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Rosedale Baltimore 1 Yes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 1612 Rosewick Avenue death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ 🗌 Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: white "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic...... Elementary/Secondary (0-12) College (1-4 or 5+) Western Electric Warehouseman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Annie Scheideggar John Christian Heil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 207 Prize Taker Court-Pasadena, Maryland 21122 John Heil, Jr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Evans Funeral Charel and Feb.21,2012 remation Services-Belair 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 21. Signature of Funeral Service Licensee tadol L-WE 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ URINAMY Tract intection disease or condition Medical resulting in death) Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir attending physician and I for use as the burial-transit TEVENE METALS Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, been sig should b 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an cate has autopsy performed? Yes 2 No certificate Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number. determined 24 hours Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆

State Registrar

within 2

only one) 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

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Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien 20 12 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ GEORGE 3:10 PM DI) Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hopsital Center Westminster 5. Social Security Number Sex 1XXM 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours Min. (Month, Day, Year) 217-16-2897 88 Maryland Oct. Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10a, State 10c. City. Town or Location Director 1 ☐ Yes 2XX No Carroll Manchester MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3570 Water Tank Road 21102 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1424 Yes 2 ☐ No If Yes, Give Year or Dates. WWII 14. Race - American Indian. ıral", or iten Examiner r Black, White, etc. by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Expediter Black & Decker 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked o any jiry or other traumatic even ene. ဂ Mary Stump Harvey C. Hann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3570 Water Tank Rd., Manchester, MD 21102 Alice E. Hann (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 2/23/2012 Hampstead, Maryland Hampstead Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, MD 21102 art). Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, not, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Aspiration Pneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XXN 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2XX No Other: 1 🗌 Yes ျာ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 000 68650 chuar 119/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Memorial Ave, Westminster, MD 21157 Tazeen Rehman, M.D., 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virginia Ellen Heying Medical 18 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St Elizabeth Rehab & Nursing Center N/A Baltimore . Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Months Davs Hours May 8, 1928 216-20-7274 83 Maryland 1 🗆 M 2 🅇 F **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 1202 Holmewood Dr. 21122 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 white 1 Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) administration should be filed with and Mental Hygien is marked other th education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Harris Sarah Pittman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Holmewood Dr Pasadena MD 21122 Gary Heying son ge 1 and 2 sl nt of Health a Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 ment of 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or permit. Page Department Important: Is any injury or Glen Haven Cemetery 2/21/2012 Glen Burnie Maryland 4 Donation 5 Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home P.A. Signatur 3111 Mountain Road Pasadena MD 21122 23a. Part 1. Enter the disease, or complifations that shock, or heart failure. List only one cause on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ distast disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (o requires that the death certificate be executed LOV and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending plant for use as IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Vear Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law perform death? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatle Funeral Director: completely filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or investigation in my control of the property of the prop Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) bruny 30. Name and address of person who completed ce use of death (Item 23a) (Type, Print) 2212 Murvland 0 2 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 710 AM Month Day Physician/ James I. Helmcamp 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLIN Square Baltimore Rusedal Hospital 8. Date of Birth April 14, 1925 Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 219-12-9301 Director 1 🛣 M 2 🗆 F 86 Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland Director Baltimore MD Essex 1 🗌 Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21221 USA 3 Goeller Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify White Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Koppers Company Steel Worker 8th Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Catherine Dignan George Helmcamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1759 Balsam Avenue Kissimmee Fl 34758 James Helmcamp /son timore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 2/24/12 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Baltimore MD 4 Donation, 5 Dother (Specify) permit. 21. Signature of Funeral Service, License 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Hemorchaei Due to (or as a consequence of) Ph. i ian/ disease or condition Medical resulting in death) Examiner Povolemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year 4 Pregnant
9 Unknown Pregnant at time of death been signed by the sahould be detached ☐ Yes ∠ □
☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending injury 1 Natural 24 hours after death. Funeral Director: A Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hound to the second Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DU067697 2105-05

Registrar

9000 FRANKLIN Square

Balto md 21237

DR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Nelia E 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Peb. 201°2 4:37 William Wesley Hartman, Jr. ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Aug. 26,1940 1 X M 2 🗆 217-38-2782 West 71 **Director** Virginia Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Millers 1 Yes 2 No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5038 Roller Rd. 21102 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Chesapeake Paper College (1-4 or 5+) Mechanic/Driver Board Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental h William Wesley Hartman Edna M. Delawder and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Doris Hartman - wife 5038 Roller Rd. Millers, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place $F \in \mathcal{B}$ 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Manchester, MD. Ch. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel Sail1 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus of each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months? Pregnant at time of death 2 🗌 No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred The Hospital or Attending 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. Director: Af 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) within 24 hours a 29a. Certifier rifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa re and title of cert on who completed cause of death (Item 23a) (Type, Print) and address of pe Westminster,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ AM HAMMEL 3;20 1 AYLOR 02 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ella MAIRIS HOSPICE 1 our SON Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min (Month, Day, Year) Director 1 X M 2 🗆 F 83 -07-1928 MD 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD BALLIMORE DUN DALK o 10e. Street and Numbe 10g. Citizen of What Country? Funeral , or items 23a SA 1222 Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 3:20 а.ш. Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: White than "natural" Completed 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. GREETER SALES RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ TAYLOR HAMMEL MARGARET GRACE 19a. Informant's Name/Relationship (Type, Print) GRANDSCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 BELDIR MD KICHARD ocher Terrace 21015 654 Baltimore, FEBRUARY 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot once. Bay View Cremator BALLIMORE MA 4 Donation 5 Other (Specify) 02-21-2012 of Funeral Service Mo 2134 WILLEW SPRING RD, Bractimoce, mid 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ MULTIPLE MYELOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine range course in the date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a contection or) -transit Due to (or as a consequence of) physician Physician/Medical Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown detached for Month Day Year Pregnant at time of death 9 Unknown EARL, HAMMEL r signed by trill be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perforn 1 Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 1 Tyes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 은 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 X Natural 5 Pending injury 1 🔲 Yes 2 L No ☐ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title 29d. Date gigned (Month, Day, Year) ×12 son who completed cause of death (Item 23a) (Type, Print) 30. Name and a 2300 DULANEY JACKIĖ JONĖS YALLEY RD. TIMONIUM, MD 21093 State Registrar

| | | State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg, No. 2 2 | | | | | | | | | | 112 | 01.8 | 2 L | | |
|--|---|---|---|--|---|--------------------|---|---|---|---|---|------------------------------------|-----------------|---------------------------------------|-----------------------------------|-------------------|
| | Physicia | ın/ | 1. Decedent's Nam | , | ot) | | | 2 | | | | 2. Date of Death Month Day | | | Death | |
| 2.00 | Medic Examir | cal | Diane 4a. Facility Name (if | f not institution, g | Y . | ber) | Ham | 4b. City, Tow | n, or Locatio | on of Death | TEBRUI | NX | 14,0 | Year Year Year Of Death | 2153 | 5 PM |
| | | | Doctor's Community H | | | , | | | Lanham | | | | Prince George's | | orge's | |
| | Funeral Director | | 5. Social Security N 577-94-1 Usual Residence | 479 | 5. Sex 1 □ M 2 X F | 7. Age (In yrs. 48 | last birthday) Yrs. | If Under 1 Ye Months Da | | der 24 Hrs. S Min. | 8. Date of Bir (Month, Da Aug • 1 | ay, Year) | 963 | Count | lace (State or ry) ington | _ |
| | //aryland 8a-f shov tified at | rector | 10a. State MD | 10b. County Prince | George' | | ty, Town or Loc | Bowie | | | | | | 10 | 0d. Inside City | |
| | with the N 23a or 2 ist be no | Funeral Director | 10e. Street and Number 4400 01ando Lane | | | ! | | | | | What Country? 1 States | | | | | |
| 980 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | þ | 11. Marital Status 1 Never Marr 3 □ Widowed | | Armed For | 2 X No | | | | | ecify Yes or No- Rican, etc.) | | 14. Rac | e - America ck, White, e | n Indian, tc. | |
| $\int_{J} \mathcal{A} \mathcal{V} \mathcal{E} \ / \mathcal{E}$ Maryland 21215-0036 | nin 72 hour ne. han "natul e Medical | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. Deced (Give k | ing | 16b. Kind of Business/Industry | | | | | | | |
| Z 5 | ed with Hygier other t | Be C | 17. Father's Name (i | | (at) | | Ne | ver Wor | 1 | other's Name | e (First, Middle, | | | Worke | ed | |
| IANE Marylan | ld be fill Mental arked atic eve | 욘 | William | | Sherman | n | | | | oroth | | , ivialueri | | Jangst | on | |
| 0, A. | nd 2 shoul ealth and I m 27 is m | | 19a. Informant's Name/Relationship (Type, Print) Deneen Agnew / Sister | | | | 2506 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 2506 Boones Lane, Forestville, MD | | | | | | rn, State, Zip Code) | | |
| 141M) U Baltimore, | Page 1 a train of H traint: If ite fury or oth | | 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | | Place of Dispos cemetery, crem sapeak | sition (Name of latory or other p Crema | on (Name of ory or other place) Crematory 02/18 | | | ı | | - | City or Town, State | |
| Ball | permit Depart Impor any in | | 21. Signature of Fine al Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 | | | | | | | | | | | | | |
| | Physician/ | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death disease or condition | | | | | | | | | | | | | |
| | Medical Examiner | _ | resulting in death) Sequentially list con | nditions, | b | or as a conseq | | | | | | | | | | |
| | ecuted and transit | Examiner | cause. Enter Under Cause (Disease or that initiated events | rlying injury | or as a bonseq | | | | | | | | | | | |
| 09 | ate be executed hysician and the burial-transit | dical | resulting in death) I | Last | Due to (or as a consequence of): d | | | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic. | | | s decedent pregnant ne past 12 menths? Yes 2 Mo 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) | | | | | | | | Date of delivery Month Day Year | | | | |
| ds, P.O | requires that the der been signed by the s should be detached | by | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| Recor | : The law re icate has be r, page 2 sh | Completed | | | | | | | - | | 24a. Was autoj perfo 1 \square Yes | psy ormed? | P 0 | Vere autops prior to com death? | sy findings ava pletion of cau | ailable use of |
| Vital | Physician: The r this certificate Feral director, page | To Be | 25. Was case referred to medical examiner? 1 | | | | | | | | | | | | | |
| on of | il or Attending Ph s after death. Director: After thi d in by the funeral | | | | | | | | | | | | | | | |
| Divisi | tal or Atters after de al Directo ed in by ti | | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify) | | | | | et, factory, offic | | ocation (Street and Number or Rural Route Number, ty or Town, State) | | | | | | |
| | To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b | Med | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | e(s) and mann | er stated. | | | |
| | P × F C | | 29b. Signature and t | Jams | | -> | | 17 | nse numbe | 7 | | 02- | 15- | signed (Month, Day, Year) | | |
| 2 | | | 30. Name and address | s of person wh | o completed cause 10 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 | of death (Item | od Luc | int) | Lar | rham | , mD | . 2 | 010 | 4 | | |
| | Stat Registra | - | 31. Date filed (Month | EB 2 1 2 | 012 3/ Re | gistrar's Signa | 1. par | Nes 1 | | | | | | | | |
| DHM | 1H 17 Rev 06-2 | | | | 1000 | | ORIGIN | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 10d, 16a, perfff, 6924, 2/21/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 8, 2012 1:55 P.M onna M EBRUARY Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL BALTIMORE ROSEDALE Social Security Number 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 719-64-7890 **Director** 1 □ M 2 🗹 show or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director timore 1 X Yes Z No 10e. Street and Number ö 10g. Citizen of What Country? ms 23a or Funeral 6029 21206 2. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ortant: If item 27 is marked other than "natural", or ite injury or other traumatic event, the Medical Examiner Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 13/ac Completed 3 🗆 Widowed 4 🗆 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Data Entry Processor Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) ᅙ ames lerr HARRIS 19a. Informant's Name/Relationship (Ty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 i 6204 5band hwood Dalfmore mo 21206 Department of Healtl Important: If item 2 any injury or other t Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location -City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) (HMORE, M!) 22. Name and Address of Facility Vavahn, Signature of Furreral Service Licen les - Greene 8728 Liber ISTOWN 23a. Part 1. Enter the disease, or/complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on-heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPERKALEM disease or condition UNKNOWN Medical resulting in death) Due to (or as a consequence of) Examiner STAGE RENAL YEARS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Live Birth 2 Line and assume the line of death Unknown Month Day Year be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> DIABETES, HYPERTENSION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? ENCEPHALOPATHY 24a. Was an has autopsy performed this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 No ျ Other: 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: within 24 hours after death.

To the Funeral Director: After I completely filled in by the funer 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2/16/11 Zeney 30. Name and address of pe person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD. 21237 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State of Maryl. State of Maryl. Registrar | - | artment of F tificate of D | | | 201 | 2 01.826 |
|---------------------------------|--|------------------|--|----------------------|--|---|------------------------------------|--------------------------|---|
| | | | Decedent's Name (First, Middle, Last) | | inoate or E | , out i | 2. Date of Death | g. No. 2 U 1 | 3. Time of Death |
| Н | Physicia Medio | | | oaugh | | | February | 7 15 201 | 2 1:23 A M |
| | Examin | er | 4a. Facility Name (if not institution, give street and number) 651 W. Adams Circle | | | Location of Death | | 4c. County of D | eath lerick |
| All the same | Funeral | | | rs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. | Birthplace (State or Foreign |
| | Director | | | 83 Yrs. | Months Days | Hours Min. | (Month, Day, Y | ,1928 I | Country) Maryland |
| | nd how at | = | Usual Residence of Decedent 10a. State 10b. County 10c. | City, Town or Loc | eation | | | | 10d. Inside City Limits |
| | Aaryla 8a-f s tiffied | rect | Maryland Frederick | | | Woodsb | oro | | 1 🎖 Yes 2 □ No |
| | a or 2 be no | | 10e. Street and Number | | 10f. Zip Code | | | g. Citizen of What | |
| | hours after death with the Maryland natural", or items 23a or 28a-f sho lical Examiner must be notified at | Funeral Director | 651 W. Adams Circle | | <u> </u> | 21798 | | υ. | S.A. |
| (0 | or iter | | 11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No | | Vas Decedent of His Yes, specify Cubar | spanic Origin? (Spe n, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - A Black, W | merican Indian, hite, etc. |
| 903 | irs afte | Completed by | 3 | 1 | ☐ Yes 2 X No | Specify: | | Specify: | White |
| 15-(| 72 hou n "nati fedica | ple | 15. Decedent's Education (Specify only highest grade completed) | (Give k | lent's Usual Occupa kind of work done d | | ing 1 | 6b. Kind of Busine | ess/Industry |
| 21215-0036 | ed within i Hygiene. other thar ent, the M | Con | Elementary/Secondary (0-12) College (1-4 or 5+) | life, DC | NOT use retired) seamst | ress | | clothing | factory |
| pu | 요소들 | | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nam | e (First, Middle, Ma | iden Surname) | , |
| yla | should be file and Mental I is marked of raumatic eve | 욘 | Murray David Smith | | | May | Elizabet | h Boone | |
| Maryland | 2 should be th and Men 27 is marke traumatic | | 19a. Informant's Name/Relationship (Type, Print) Judy Bohn/ daughter | | g Address (Street a | | Route Number, C Fairfiel | | |
| a) | 1 and 2 s of Health item 27 | | 20a. Method of Disposition 20 | b. Place of Dispos | sition (Name of | | | Oc. Location - City | |
| imo | Page ment c ant: If ury or | | 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) | | natory or other place 11 Cemete | · . | 8/2012 r | r. Woods | sboro, MD |
| Baltimore, | permit. Page 1 a Department of I Important: If ite any injury or of | | 21. Sig. thre of Furieral Service Licensee | / | Name and Addres | | rtzler Fu Woodsbor | | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line. | | | | | <u> </u> | Approximate Interval Between |
| | Physician/ Medical | | Immediate Cause (Final disease or condition resulting in death) | | c BRE | AST | CANCE | ٤ | Onset and Death |
| | Examiner | | Due to (or as a cons | sequence of): | | | | | |
| v | | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | equence of): | * | | | | |
| | cuted and transi | Examiner | Cause (Disease or injury that initiated events c. | | | | | | |
| 0 | cate be executed physician and s the burial-transit | | resulting in death) Last Due to (or as a cons | sequence oi): | | | | | |
| 3760 | | Medical | d | | | | | | |
| x 68 | eath certifica attending p | lan/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ F | etal death 3 | Ectopic pregnancy | y | | 23d. Date of | , |
| Box | ne deat / the at ched fo | Physician/M | 1 | of death 5 | Other (specify) | | | Month | Day Year |
| P.0 | requires that the develeen signed by the sendid be detached | by P | Part II. Other significant conditions contributing to death but not | resulting in the ur | nderlying cause give | en in Part I. | | | e to the cause of death? |
| rds, | equires sen sig nould k | | | | | | 1 🗆 Yes | 2 🗆 No 3 🗆 | Probably 4 Unknown |
| Division of Vital Records, P.O. | The law reate has by page 2 st | Completed | | | | | 24a. Was an autopsy performe | prior | autopsy findings available to completion of cause of 1? |
| <u>m</u> | ilcian; The certificate rector, paç | | 25. Was case referred to medical | | 26. Pla | ice of Death (Check | 1 \(\text{Yes} \) 2 | No 1 🗆 | Yes 2 No |
| ∠it | nysician; T | To B | examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 | ☐ ER/Outpatien | Othe | y- | me 5 Residen | ce 6 Other (Sp | pecify) |
| n of | Attending Ph ar death. ector: After th by the funeral | Certificate: | 27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) | 28b. Time of injury | 28c. Injury work? | at ? Yes 2 \(\sum \) No | 28d. Describe how | injury occurred | |
| Sio | l or Attending after death. Director: After I in by the fune | rtific | 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - Al | t home, farm, stre | | | | | Rural Route Number, |
| Ω | Italor Irs afte al Dire | | bullaing, etc. (Spe | | | | City or Town, S | | |
| | To the Hospital or Attending Physician; The law requires that the death certification 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examina 3 Certifying Nurse Practitioner: To the best | ation and/or investi | gation, in my opinior | n, death occurred at | the time, date and p | place, and due to the | ne cause(s) and manner stated. |
| | To t with To t | | 29b. Signature and title of certifier Double MA | | 29c. License | number 1936 | 290 | Date signed (Mo | nth, Day, Year) |
| | | | 30. Name and address of person who completed cause of death (II ANDREN SINECSON, MD 65 | tem 23a) (Type, Pr | rint) | | | | |
| | Stat Registra | ~ | 31. Date filed (Month, Day, Year) FEB 2 1 2012 32. Registrar's Sig | nature A | bake | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ 6:43 AM MARGARET HIT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Good Samaritan Hospital 8. Date of Birth (Month, Day, Year) Yarch 9, 1927 Social Security Number Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Min. 1 M 2 XX Hours 026-30-4767 84 Germany **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director MD 1 XXYes 2 □ No N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 115 East Melrose Avenue 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces b 1 Never Married 2 Married 1 Yes 2 WNo
If Yes, Give XX
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. and Mental Hygiene. Specify: White 3 ₩Widowed 4 □ Divorced Completed Pargaret Hit 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Homemaker Elementary/Seconday (0-12) College (1-4 or 5+) Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important. If item 27 is marked any injury or con-12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hans Day 2 Anna Hofheinz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 653 Windsor Drive Westminster, MD 21158 Marlene Riggs (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/21/12 Atlantic Crematory Glen Burnie, MD 21. Signature of Euneral Se 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. Falls Road Balto, MD 21211 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on such line. 23a. Part 1. Enter the diseas Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pre 3 Ectopic pregnancy in the past 12 mg Month Pregnant at time of death 5 Other (specify) signed by the at d be detached fo esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed 2 No has page 2 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA 1 ☐ Inpatient 2 completed filled in by the funeral 27. Manner of D th 28a. Date of injury (Month, Day, Year 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Medical Certificate: within 24 hours after death. To the Funeral Director: After 1 Natural iniury 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur

Registrar

State

Name

cause of death (Item 23a) (Type, Print)

ar's Signature

Regist

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| yne Har | nson | | St 1- For State Registrar | ate of Maryl | • | artment of | | and Ment | al Hyg | | 2 (g. No. | 012 0482 | | |
|---|--|---------------|---|---------------------------------|---------------------------------------|--|---|---|-------------|---|--------------------------------|--|--|--|
| Phy edical E | ysici | | Decedent's Name (First, Midd | • | | | How | 200 | | Date of Deat Month February 1 | h | 3. Time of Death | | |
| | | | 4a. Facility Name (if not institution | n, give street and n | | 1 | | SON or Location of | | rebluary i | 4c. County o | | | |
| _ | | | Western Maryland Re 5. Social Security Number | gional Medical | | last histhday) | Cumberla | | Oalles I | 9. Data of Bird | Allegany | | | |
| | neral ector | | 476–72–3314 | 1 X M 2 F | 7. Age (In yrs. | Yrs | | Year If Under Days Hours | Min. | 08/30/ | | 9. Birthplace (State or Foreign Country) | | |
| | | | Usual Residence of Decedent | | | | | | | 00/30/ | 1300 | | | |
| P | how any | Ŀ | 10a. State 10b. County MN Dougle | as | 10c. City | r, Town or Locati CONA | ion | | | | | 10d. Inside City Limits 1 Yes 2 No | | |
| 5-0036 led within 72 hours after death with the Maryland Hygene. | ns 23a or 28a-f show be notified at once. | Director | 10e. Street and Number | | | | 10f. Zip Cod | е | | 10 | g. Citizen of Wh | at Country? | | |
| th the 1 | 23a or notifie | | 4491 Jerome Road I | | | | 56354 | | | | J.S.A. | | | |
| eath wi | items ust be | Funeral | 11. Marital Status 1 X Never Married 2 M | arried Armed F | cedent Ever in U forces? 2 X No | | | Hispanic Origii ban, Mexican, I | | | 14. Race White | - American Indian, Black, , etc. | | |
| after d | al", or iner m | by Fu | | orced If Yes, Give Ye or Dates: | ar | | Yes 2X | | | - | Specify: | White | | |
| 2 hours | "natu | | 15. Decedent's Education (Spe Elementary/Secondary (0-12) | | 1-4 or 5+) | | | ipation (Give ki life. DO NOT u | | | 16b. Kind of Bus | siness/Industry | | |
| 036 ithin 73 | fedical | Completed | 12 | | 4 | Consult | tant | | | | Dept. Of | Navy | | |
| 215-0036 be filed within 7 | narked other than "nat | Be Col | 17. Father's Name (First, Middle, Richard | Last) Danie | e] | Har | nson | 18.Mother's Verne | • | | laiden Surname) Vendla | Hanson | | |
| e e = | is mark tic even | To B | 19a. Informant's Name/Relations | hip (Type, Print) | | | | reet and Numb | per or Rur | al Route Num | ber, City or Town | n, State, Zip Code) | | |
| , MD and 2 st ealth an | rauma | | Vernette V. Hanson 20a. Method of Disposition | n, Mother | 20b. | Place of Dispos | | ad N.E. M | | a, MN 56 Date | | City or Town, State | | |
| Baltimore, permit. Pages 1 a Department of He | tant: If item 27 is m or other traumatic | | 1 X Burial 2 Cremation | | rom State | crematory or oth | ner place) | - " | | 2/2012 | ill Twp. MN | | | |
| altin mit. P | Important: injury or oth | | Donation 5 Other Si 21. Signature of Funeral Service | | | | ess of Facility | | | Ruck, Inc. | <u> </u> | | | |
| | _ | | 23a. Part I. Enter the disease, or | an | | | nd Road E | Baltim | ore, MD | 21214 | <u> </u> | | | |
| Physic /Med | nicai | | failure. List only one cause | on each line. | | | • | ng, such as car | rdiac or re | espiratory arre | st, snock, or nea | Approximate Interval Between Onset and Death | | |
| ≛xam | iner | | Immediate Cause (Final disease or condition resulting in death) | | a consequence of | | case | - | | | | | | |
| | | Jer | Sequentially list conditions, if any, leading to immediate | b. Due to (or as | a consequence o | of): | | | | | | | | |
| An | | Examine | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as | a consequence o | of): | | | | | | | | |
| Secuted | ician and irial - transit | dical E | [] INDENDED | d | | | | | | | | | | |
| - e | ysician burial | Medic | UNPENDED IF FEMALE: | AMENDED 23c If yes | outcome of preg | inancy | | | | | 23d. Date of o | delivery | | |
| Box 68760, death certificate be | e attending physic for use as the bur | ian/ | 23b. Was decedent pregnant in the past 12 months? | 1 Live | | 2 Fe | | 3 Ectopic | pregnanc | у | Month | Day Year | | |
| Box 68760 e death certificate b | the atter ed for us | Physician/Me | 1 Yes 2 No 9 Uni | (nown 9 Unkn | | ∍atri 5 Oti | ner (Specify) | | | | | | | |
| | ned by | by P | Part II. Other significant condit | ions contributing t | o death but not r | esulting in the u | nderlying caus | se given in Part | t I. | _ | | pute to the cause of death? Probably 4 Unknown | | |
| 'ds' require | been sig | ound be | | | | | | | | 24a. Was a | n 24b. W | Vere autopsy findings available | | |
| Reco | After this certificate has been signed by uneral director, page 2 should be detach | Completed | | | | | | autops perform 1 Yes 2 | med? de | nor to completion of cause of eath? Yes 2 No | | | | |
| Cian: | certific ector, p | BeC | 25. Was case referred to medica examiner? | Hospital: | | 1 | | Other | | | | | | |
| of Vi g Physi | After this funeral dir | <u>۲</u> | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date | of Injury | ER/Outpatient 28b. Time of Ir | | njury at Work? | Nursing I | | Residence 6 ow injury occurre | Other. | | |
| - Ē. | | ation | 1 Natural 5 Pend 2 Accident Inves | | h, Day.Year) | | 1 | Yes 2 N | No | | | | | |
| Division of Vital Records, rat or Attending Physician: The law requir is after death. | To the Funeral Director: completely filled in by the | Certification | 3 Suicide 6 Coul | | | t home, farm, street, factory, office building, etc. 28f. Location (Street or Town, State) | | | | | | er or Rural Route Number, City | | |
| DIV To the Hospital or within 24 hours afte | Funer tely fil | | 29a. Certifier (Check only 1 Certifying Pl | nysician: To the be | st of my knowled | | death occurred at the time, date and place, and due to the cause(s) and manner as stated. If investigation, in my opinion, death occurred at the time, date and place, and due to the cause. | | | | | | | |
| ∓ :2 | 200 | | | | | ariaror invostigat | ion, in my opin | icense number 29d. Date signed (Month, Day, Year) | | | | | | |
| T. wit | To the Fur completely | Medical | 29b. Signature and title of certifie | and manner : | stated. | | 29c. Lice | ense number | | | 29d. Date signe | ed (Month, Day, Year) | | |
| To Witi | To the comple | Med | | | stated. | | | onse number C.M.E. | | | 29d. Date signe February 17 | | | |
| 3 0 | To the comple | Med | | who completed cau | | | 0.0 | | Saltimor | e MD 212 | February 17 | | | |

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 6

| | | | Plea | se Type | | | | | | | | - | | _ | ible. | | |
|--|----------------|---|---------------------------------------|--|-------------------------|----------------------------|---|----------------------------|--|----------------|--------------------|---------------------------------|---------------------|------------------|--------------------------|----------------------------|--------------|
| | - | For State | | State | e of M | larylar | | | ent of F ate of D | | and I | Mental Hy | /gien | е | 1 0 | 0.1 | 000 |
| _ | | Registrar 1. Decedent's Name | e (First, Middle | , Last) | | | Ce | runce | ile of L | <i>Jeain</i> | | 2. Date of D | Reg. N | 0. 2 | 12 | 3. Time of | B Z Y |
| Physician. Medica | | Jean | He | aton | | | | | | | | Februs | D | il, 20 | Year | 1:55 | |
| Examine | | 4a. Facility Name (if Harbo | not institution, | | number) | | | | ty, Town, or | | of Death | | / / | c. County | of Death | | |
| Funeral Director | | 5. Social Security No 217–40–1238 | | 6. Sex 1 \(\text{M} \) 2 \(\text{X} \) | 7. Ac | o (In yrs. | last birthday) Yrs. | - | der 1 Year | If Under | r 24 Hrs. Min. | 8. Date of B (Month, D | irth lay, Year) | 1942 | 9. Birth Cour Mary | place (State o | or Foreign |
| | ŀ | Usual Residence of | | | | | | | | | | pecelibe | 12, | 1942 | | | |
| laryland 3a-f sho ified at | ector | 10a. State Maryland | 10b. County | | | | ty, Town or Lo imore | ocation | | | | | | | | 10d. Inside Ci 1 🔼 Yes | ity Limits |
| leath with the Maryland items 23a or 28a-f sho ler must be notified at | | 10e. Street and Nun 546 East Fo | | ue | | | | | Zip Code 230 | | | | | Sitizen of W | /hat Cour | ntry? | |
| in in in in in in in in in in in in in i | ≥ | 11. Marital Status 1 Never Marri 3 Widowed | | ried 1 🗆 \ If Yes, | Forces? | | | If Yes, sp | edent of Hi ecify Cuba 2 🔀 No | n, Mexica | in, Puerto | ecify Yes or No Rican, etc.) | - | | k, White, | can Indian, etc. ite | |
| in 72 hour e. nan "natu Medical | Confibilities | (Spe | cify only highe | nt's Education est grade comple | ted) e (1-4 or | 5+) | (Give life, L | kind of v | sual Occupa vork done d use retired) | | st of work | king | | Kind of Bu | | dustry | |
| Hygien other the | | 1Z. Father's Name (/ | | acti | | | Unde | rwrit | er | 40 84-46 | | ne (First, Middle | | suranc | _ | | |
| Ild be file Mental I narked o natic eve | - 1 | Vernon Lynch | h | | | | , | | | | | allace | e, ivialder | i Surname, | , | | |
| nd 2 shouealth and m 27 is not traum | 1 | 19a. Informant's Na Matthew Jone ———————————————————————————————————— | ame/Relationsh ES SOI | | | <u>.</u> | 19b. Mail 3760 | ing Addre B iggi | ess/Street a n Churc | nd Numb Roa | er or Rur d Jac | al Route Numb ksonville | er, City o e, FI | orida Orida | 32224 | Code) | |
| Page 1 au nent of H int: If ite | | 20a. Method of Disp 1 🛣 Burial 2 ☐ 4 🗌 Donation | ☐ Cremation | 3 ☐ Removal f | rom State | | Place of Disp cemetery, cre Cross | matory o | r other plac | e) F | | Date ry 15, 20 | | | | own, State irk, Mar | yland |
| permit. Departr Imports any inju | | 21. Signature of Fur | neral Service L | icensee | | 1 | 270 2 | 2. Name | and Addres | s of Facili | ityMcCu ue Ba | lly Poly ltimore, | niak 1 MD 2 | Funera 1230 | 1 Hom | e P.A. | ,, |
| | | 23a. Part 1. Enter the shock, or hear | he disease, or rt failure. List o | complications the | nat cause n each lin | d the deat | | | | | | | | | | Approximat Interval Bet | |
| Physician/ Medical | | Immediate Cause (disease or condition resulting in death) | | a. Due | EPSIS | a conseq | uence of): | | | | | | <u> </u> | - | | Onset and I | Death |
| Examiner | 5 | Sequentially list con | nditions, | | | vno (| compre | mis | ed | Stat | te | | | | \perp | | |
| executed ian and inal-transit | Yall | if any, leading to im cause. Enter Under Cause (Disease or i that initiated events | rlying iinjury s | c. <u>C</u> | and | er | | | | | | | | | | | |
| (a) Fig. (b) | : 1 | resulting in death) L | _ast | d | to (or as | a conseq | uence of): | | | | | | | | _ | _ | |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu Medical Certificate: To Re Completed by Physician/Medical | ysicially ivid | IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ┺ 9 ☐ Unknown | months? No | 4 🗆 F | ive Birth | | aldeath 3 | ☐ Ectopi ☐ Other | | у | | | | 23d. Date Mor | | - | Y ear |
| requires that the de been signed by the should be detached | | Part II. Other signifi | icant condition | | to death l | out not res | sulting in the | underlyin | g cause giv | en in Part | : 1. | | | | | he cause of d | |
| The law require sate has been signage 2 should be commended. | | 6. 34 | | 7.010 | | | | | | | | 24a. Was | s an | 24b. W | /ere auto | psy findings | available |
| The lar | 5 | | | | | | | | | | | auto perf 1 Yes | ormed? | | eath? | mpletion of c | ause or |
| ician: certific ector, | 3 | 25. Was case referre examiner? | | Hospital: | | | | | | | ath (Chec | k only one) | | | | | |
| Physic arthis o eral dire | | 27. Manner of Death | _ No n | 28a. D | ate of inju | Iry | ER/Outpatie | | 28c. Injury | 4 ⊔ N | lursing Ho | ome 5 Res | | | |) | |
| or Attending Physician: The law after death. Director: After this certificate has in by the funeral director, page 2. Certificate: To Be Comm | | 1 🗶 Natural 2 ☐ Accident 3 ☐ Suicide | 5 ☐ Pendin Investig 6 ☐ Could i | gation | Aonth, Da | | in jury | М | | ? Yes 2□ |] No | | , | | | | |
| To the Hospital or Attending Phyminin 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Martical Certificate. | | 4 Homicide | determ | ined 28e. Pl | | ury - At ho c. (Specifi | ome, farm, st | reet, facto | ory, office | | | 28f. Location City or To | | | r or Rural | Route Numb | er, |
| he Hospital in 24 hours he Funeral pleted filled | | (Check 2 | ☐ Medical E | Physician: To the xaminer: On the Nurse Praction | basis of e | examinatio | n and/or inves | stigation, i | n my opinio | n, death o | ccurred a | t the time, date | and plac | e, and due | to the car | use(s) and ma | nner stated. |
| Northin Comp | | 29b. Signature and t | - 11 | noon | n | 1D | | 2 | 9c. License | | 3 | | 100 | ate signed | | Day, Year) | 2_ |
| 5 | | 30. Name and addre | ess of person v | | | | | | | | | , mD | | 225 | <u> </u> | | |
| State Registrar | | 31. Date filed (Month | | Y - | | ar's Signa | | | 0 | - > [1] (1 | w, C | | | - - | | - · · · | |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Fer FH G925 3/06/2012 JH

| | | | For State | State of Ma | aryland | | | | and M | lental Hy | giene | | 01000 |
|----------------------------|---|--------------------------|--|--|-----------------|--------------------|--|---------------|------------------|---------------------------------|--------------------|-----------------------------------|-------------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle, La | not) | | Cer | tificate of L | Death | | | Reg. No. 2 | 112 | 04830 |
| п | Physicia | ın/ | T - | , | Uowt | | | | | 2. Date of De Month | Day | Year | 3. Time of Death |
| £1. | Medic Examin | | James Le 4a. Facility Name (if not institution, giv | | Hart | man | 4b. City, Town, or | r Location (| of Death | 02 | 19 4c. County | 2012 | 6:45A M |
| - |) LAGITIII | ici | 1107 Armistead S | | | | | a Bur | | | | | rundel |
| | Funeral | | 5. Social Security Number 6. S | | e (In yrs. last | t birthday) | If Under 1 Year Months Days | | | 8. Date of Bir (Month, Da | th | 9. Birth | place (State or Foreign |
| | Director | l | | 1 ∑ M 2 □ F | | Yrs. | Worldis Days | riouis | I WILL. | 01/26/ | | Coun | st Virginia |
| | nd thow | 5 | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, | Town or Loc | ation | | | 01/20/ | 1,20 | | 10d. Inside City Limits |
| | Aaryla 8a-f s tified | Director | MD Anne A | Arundel | G1e | n Bur | nie | | | | | | 1 ☐ Yes 2🏋XNo |
| | the Na or 2 | | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citizen of | What Cour | ntry? |
| | h with | Funeral | 1107 Armistead S | Street | | | 21061 | | | | USA | | |
| Maryland 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? XX Yes 2 If Yes, Give Year or Dates. | | lf If | Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2XXNo | ın, Mexicar | n, Puerto F | cify Yes or No- Rican, etc.) | | ce - Americ ck, White, Whi | etc. |
| 5-(| 2 hou " nat edica | ple | 15. Decedent's E (Specify only highest g | | | (Give k | ent's Usual Occup | | t of workin | ng | 16b. Kind of B | usiness/In | dustry |
| 12 | ithin 7 ene. • than he M | Completed | Elementary/Secondary (0-12) | College (1-4 or 5 | i+) | | NOT use retired) | | | | NS. | Δ | |
| d 2 | led w Hygi other ent, t | Be | 17. Father's Name (First, Middle, Last) | | | Ana | Tyst | 18, Mothe | er's Name | (First, Middle, | Maiden Surnam | | |
| ılan | d be fill dental irked tic ev | မ | Hallie Hartman | | | | | | | a Healy | | , | |
| lan | should and N is ma auma | | 19a. Informant's Name/Relationship (| Type, Print) Wife | | 19b. Mailin | g Address (Street a | and Numbe | er or Rural | Route Numbe | r, City or Town, S | State, Zip (| Code) |
| €, | and 2 Health | | Mrs. Jean Hartma | in / Daught | | | 7 Armist | ead S | treet | t Gle | n Burni | e, MD | 21061 |
| Baltimore, | nt of H | | 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ | Removal from State | cen | netery, crem | sition (Name of atory or other plac | | | ate | 20c. Location | | |
| Ħ | nit. Pa artmer ortant injury | | 4 Donation 5 Other (Spec. | | I MD V | | ns Cemete | | | | Crown | | |
| Ba | Depar Impor any ir | | 21. Olgitature of Africa Gero | MOD | 26 | | Name and Addres | | - | - | | | MD 21061 |
| | | | 23a. Par 1. Enter the disease, or corr shock, or heart failure. List only | plications that caused | the death. I | | | | | | | | Approximate |
| 201 | h, sician/ | | Immediate Cause (Final disease or condition | The cause off each line | - (1 | | Drune | .4. | | | | | Interval Between Onset and Death |
| - | Medical Examiner | | resulting in death) | a. Due to (or as a | consequen | of): | Direct | 6 1 1 4 | | | | | 3 9:0012 |
| | | ie e | Sequentially list conditions, | b | | | | | | | | | |
| 0.4 | ed nsit | Examiner | if any, leading to immediate Cause (Disease or injury | Due to (or as a | a consequen | ice of): | | | | | | | |
| D | xecut al-trar | Exa | that initiated events resulting in death) Last | c. Due to (or as a | a consequen | nce of): | | | | | _ | \dashv | |
| 09. | cate be executed physician and s the burial-transit | dical | | d | | | | | | | | | |
| 876 | tificate ng phy as th | w | IF FEMALE: | | | | | | | | | | |
| Box 687 | eath certifica attending p | Completed by Physician/M | 23b. Was decedent pregnant in the past 12 months? | | 2 🗌 Fetal d | leath 3 🗌 | Ectopic pregnanc | y | | | | te of delive | , |
| Bo | e deat the at hed fo | ysic | 1 Yes 2 No | 4 ☐ Pregnant at 9 ☐ Unknown | time of dea | ith 5 | Other (specify) | | | | Mo | onth | Day Year |
| P.0. | requires that the der been signed by the s should be detached | / Ph | Part II. Other significant conditions of | contributing to death bu | ut not resulti | ing in the ur | nderlying cause giv | en in Part I | l. | 23e. Did to | bacco use cont | ribute to th | ne cause of death? |
| S, F | uires tl signe | q p | | | | | | | | 1 🗆 | Yes 2 0 | 3 🗆 Prob | bably 4 🗆 Unknown |
| ord | w requ | olete | | | | | | | | 24a. Was | | Were autor | osy findings available |
| 3ec | Physician: The law of this certificate has the areal director, page 2 s | mo | | | | | | | | autor perfo 1 \square Yes | rmed? | prior to cor death? 1 □ Yes | mpletion of cause of |
| <u>a</u> | ian: T | | 25. Was case referred to medical examiner? | | | | 26. Pla | ace of Deat | th <i>(Check</i> | | 2 92010 | 1 🗀 163 | 2 🗆 110 |
| Ξ | hysic this ce al dire | 유 | 1 Yes 2 No | Hospital: 1 ☐ Inpatie | | <u> </u> | 3 DOA Othe | er: 4 🗌 Nu | ursing Hon | ne 5 Resid | lence 6 🗆 Othe | er (Specify, |) |
| l of | I or Attending P s after death. I Director: After t d in by the funers | Certificate: | 27. Manner of Dealh 1 ☑ Natural 5 ☐ Pending | 28a. Date of injur (Month, Day, | | Bb. Time of injury | 28c. Injury work | ? | ı | 8d. Describe h | ow injury occurr | эd | |
| siol | Attend deatl ctor: by the | rtific | 2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined | oe 280 Place of Injur | rv - At home | e, farm, stre | | Yes 2 🗆 | - | 9f Location /9 | treet and Numbe | er or Rural | Poute Number |
| Division of Vital Records, | pital or A | | 4 ☐ Homicide determined | building, etc. | . (Specify) | ,, | .,,, | | | City or Tow | | si Oi Haiai | riodie Nambei, |
| _ | lospit: Houn unera ely fille | Medical | 29a. Certifier (Check 2 Medical Exam | rsician: To the best of r | my knowledg | ge, death or | ccurred at the time | , date and | place, and | d due to the ca | use(s) and manr | ner as state | ed. use(s) and manner stated. |
| | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic. | | only one) 3 L Certifying Nur | se Practitioner: To the | best of my l | knowledge, | death occurred at the | ne time, dat | te and plac | e, and due to t | ne cause(s) and n | nanner as s | stated. |
| _ | P ≥ ≥ P 8 | | Zab. Signature and title of certifier | 1 6. 0 | 1 | 221 | 29c. License | number | 76 | , | 29d. Date signed | 1 (Month, E | Jay, Year) |
| | 5x1 | | 30. Name and address of person what | completed cause of de | eath (Item 23 | Ba) (Type Pr | int) Char | -6.A | T. | Maci | 2- m >- le | Man | 12 |
| | U | | 30. Name and address of person who | -i-deide | 20 | 3 2 6 | THE IS I | 0 1 | / | J 10 CC | 3(10 | 100 | 1 |
| | Stat | е | S1. Date filed (Worth, Day, Tear) | 82. Registrar | r's Signature | J. 57. 7 | | | | | | | |
| | Registra | ir | FEB 2 1 2012 | Buch | 2. | Back | | | | | | | |

12-01452 Llovd Alvin Hartz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 04831

| ioyu Aiviii Haitz | | For State Control of Pleath Control of Pleath | Reg. No. | |
|--|----------------|--|---|---|
| Physicia | _ | Registrar 1. Decedent's Name (First, Middle, Last) | 2. Date of Death | 3. Time of Death |
| Medical Examin | | Lloyd Alvin Hartz | February 18, 2012 | 0925 NIS |
| | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea Veterans Hospital Baltimore | th 4c. Coun | ty of Death |
| | | Votorano i respirar | rs. 8. Date of Birth(MM/DD/YY | YY) 9. Birtholace (State or |
| Funeral Director | < | 227-26-5715 1 M 2 F 89 Yrs. Months Days Hours M | | Foreign Country) |
| Ì | - | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | 10d. Inside City Limits |
| A | 5 | MD NIA Baltimore | | 1 Yes 2 No |
| | | 811 N. Augusta Ave 10f. Zip Code 21229 | | What Country? |
| death with | Funeral | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer | | ace - American Indian, Black, hite, etc. |
| ral", o | <u>ا</u> | 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 ✓ No specify: | Special Special | business/Industry |
| hours | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re | | Business/industry |
| D36 thin 72 ne. then fedical | Completed | 12 Self Employ | yed Hom | e Improvement |
| 21215-0036 uld be filed within 7. Mental Hygiene. marked other than | | The delication of the state of | ne (First, Middle, Maiden Surna | |
| 2121 uld be fi Mental marked | 8 | John HVIN ITAVTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number of Str | a Jones | |
| MD 2 id 2 shoul filth and N m 27 is m | ᅀ | Daisy Hartz 1811 N. Augusta | | inoce, MD 21229 |
| e, N 1 and 1 Health Titem | ŀ | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, | Date 20c. Location | on - City or Town, State |
| MOCE Pages 1 nent of H nut: If i | | 4 Docation 5 Other Specify: | | Himore, MD |
| Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other fraus | 1 | 21. Smallure of Funeral Service Licensee 22. Name and Address of Facility 3331 Blehms | | moral Home |
| Physician | 1 | 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. | | / |
| Examiner | i | Immediate Cause (Final disease or condition resulting in death) a. Complications of Recurrent Aspiration of Due to (or as a consequence of): | on | Death |
| | | Sequentially list conditions, if any, leading to immediate b | | |
| | 틭 | Course. Enter Underlying Course C | | J. J. L. |
| cuted and transit | Examine | events resulting in death) Last Due to (or as a consequence of): d | | |
| 60, ate be exe hysician a | Medical | ■ UNPENDED □ AMENDED 23a,pt.II,27,per me,g932 10-17 | | |
| 876(ifficate ng phy | | IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg | | e of delivery n Day Year |
| Box 68760, cleath certificate be executed the attending physician and of for use as the burial - transil | Physician/I | 4 Pregnant at time of death 5 Other (Specify) | | |
| b. BC the dea | Ä | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use co | ontribute to the cause of death? |
| s, P.O. Bi | | Hypertensive Atherosclerotic Cardiovascular Disease | 1 ☐ Yes 2 ✔ No | 3 Probably 4 Unknown |
| Division of Vital Records, P.O. rial or Attending Physician: The law requires that the ris after death. -I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach. | Completed by | Dementia; Seizures; Chronic Renal Disease | | Were autopsy findings available prior to completion of cause of |
| eco he law tte has | E C | bemereta, berzates, ontonie kenar bisease | performed? 1 ✓ Yes 2 No | death? 1 ✓ Yes 2 No |
| nn: Ti | 8 | 25. Was case referred to medical 26.Place of Death (Chec | | |
| Vita hysici this ce | ટા | Tes 2 No | sing Home 5 Residence | |
| n of ding P. After funera | | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? | 28d. Describe how injury occ | curred |
| SiOI Atten r death ector: by the | cati | 2 Accident Investigation 28e Place of Injury - At home farm, street, factory, office building, etc. | 28f. Location (Street and Nu | mber or Rural Route Number, City |
| Divi | Certification: | 3 Suicide 6 Could not be determined (Specify) | or Town, State) | |
| - G. G. G. | calc | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a (check only note) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred | nd due to the cause(s) and mar d at the time, date and place, ar | nner as stated. nd due to the cause(s) |
| To Taithing Sommy | Medical | and manner stated. 29b Signature and title of certifier 29c. License number | | signed (Month, Day, Year) |
| | | (clockett) O.C.M.E. | February | y 19, 2012 |
| 4 | ŀ | 30. Name and address of person who completed cause of death (Item 23a) | | |
| P | | Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore | , MD 21223 | |
| Sta Regist | ate | 31. Date filed (Month, Day, Year) 32. Registrar & Signature 33. Registrar & Signature 33. Registrar & Signature 34. Registrar & Signature 35. Registrar & Signature 36. Registrar & Signature 37. Registrar & Signature 38. Registrar & Signature 39. Registrar & Signature 40. Registrar | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ EDWARD JAMES HUTCHINS SR. 2012 8:50 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 203 Donerail Court Havre de Grace If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🖾 M 2 🗆 F Months Days Hours (Month, Day, Year). Country) New York 216-16-3788 90 Jan. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturor" any injury or other traumatic ence. 10b. County 10d, Inside City Limits 10a, State 10c. City. Town or Location Director 1 Yes 2X No Maryland Harford Havre de Grace 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 USA 203 Donerail Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status rmed Forces?

XYes 2 \(\square\$ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 X Married 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: USA Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Owner Operator Cleaners Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas William Hutchins Molly Elizabeth Haran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 203 Donerail Court, Havre de Grace, Maryland Blanche E. Hutchins/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gdn. 2/21/2012 Bel Air, Maryland # Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 13 Cu 10 Lys 00 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 79 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte 5 Other (specify) Pregnant at time of death ☐ Pregnam.
☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy performe death?
1 Yes 2 No certificate Yes 2 No **Division of Vital** 25. Was case referred to medical director, 26. Place of Death (Check only one) Be 1 🗆 Yes 2 No 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 1 Natural Accident 5 Pending 2 🗌 No 24 hours after death. Funeral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 1 Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

29a. Certifier

(Check

only one 29b. Signature and title of

MIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILLEans 32, Registrar's Si

Registrar DHMH 17 Rev 7/2009

within 2 To the F

MD 1106

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Revalution St

29d. Date signed (Month, Day, Year)

Maryland 21215-0036 2012 20,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 February 2012 1:57 Connye Frances Rice Heinonen AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Timonium 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** (Month /02/1959 1 🗆 M 2 🖰 F Days Maryland 219-78-0605 52 Director 28a-f shov 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at Director 1 X Yes 2 □ No MD Baltimore Essex 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be r Funeral 811 Briar Hill Place, Apt. F 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home 10 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ injury or other traumatic Lawrence Edward Rice Margaret Ellen Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Philcia Corrine Ford / Daughter 811 Briar Hill Place, Apt. F, Essex, MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2/21/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licen 22. Name and Address of Facility any Dorota Marshall Maryland Cremation Services, PO BOX 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition LIVER DISEASE Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease of injury that initiated events resulting in death) Last burial-trans and Due to (or as a consequence of) attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 X No for Month 5 Other (specify) Day Year Pregnant at time of death ed by the a detached f signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 certificate 2 No 1 Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\mathbb{X}\) Other (Specify) 2 X No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 \square Yes 28d. Describe how injury occurred 5 Pending X Natural Division 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature ar 29c. License numbe 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **JACKIE** JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 21

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fe beuary 1:11 P M GARY ANTONE HNYLA, SR. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARUNDE ANNE Buenie Baltimore Washington Medical Center Glen If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 X M 2 | F Days 69 38 3042 MD **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2. No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 U.S.A. 135 Carroll Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?

1 🕱 Yes 2 🗆 No 1964 If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2.X No Specify. Specify: 3 Widowed 4 Divorced White 1968 Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) 12 College (1-4 or 5+) Fire Department Fire Fighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Genevieve Downey Jerry Antone Hnyla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hnyla - Wife 135 Carroll Rd Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/20/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funer Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home 21122 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NoumoniA Ptwwician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 500 G Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): ending physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ YMPHOLINE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 Yes 2 H 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 🖪 No 1 🗌 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred e Hospital or Attending Post hours after death.
e Funeral Director: After the Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29b. Signature and title of certific FEBRUMY 14,2012 0055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLIN GUZNE MIS Contin WASHINGTON MCDICITE J'MONG

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Registrar

31. Date filed (Month, Day, Year) FEB 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 13^{ay} Physician/ 1:40A 02 2012 Dorothy M. Harrell Medical 4b. City, Town, or Location of Death **Baltimore**. 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Joseph Ritchie 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 219-52-3979 **Funeral** (Month, Day, Year) Days Hours Director 1 🗆 M 2 🔀 F 01/10/1947 Maryland 65 ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 XYes 2 No Baltimore MD N/A 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21223 U.S.A. 1806 Penrose Ave. ural", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Examone. 1 Yes 2 XNo Specify: Specify: Black Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) lementary/Secondary (0-12) College (1-4 or 5+) Sweetheart Cup Co. Laborer 9th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Annie Wiggins John Harrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1076 1/2 W. Boulevard Los Angeles, CA90019 Kevin Harrell (son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 02/18/12 Baltimore, MD King Mem. Park 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home PA MD21217 2140 N. FUlton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PANCIENT:C Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Dis6 to (or as a consequence of) if any, leading to humediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burlal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 Harrell IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ ate has been signed by the atterpage 2 should be detached for in the past 12 months? Day Year Month 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Doro thy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Hypenonsion 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hegat. T.s 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2: performed? Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\mathbb{Z}\) Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: or Attending Fafter death. 1 Natural 5 Pending 2 Accidem
3 Suicide
4 Homicide Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

N

0

(Check

29b. Signature and title of certifier

Cynthia

31. Date filed (Month, Day, Year)

FEB 21

racks

DO

Joseph

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shen

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospice

H0062554

29d. Date signed (Month, Day, Year)

Baltimore.

02 13 2012

NORTH EUTOW STRET

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

| | | | | For State | I. | State o | of Maryla | | oartme e <i>rtifica</i> | | | and M | 1ental Hy | giene Reg. No. 2 | 012 | 04838 |
|----------|-------------|---|------------------|--|--|---|---|--|---|---|--|--------------------|---------------------------------|-----------------------------------|--|---|
| | | Physicia | _ | Registrar 1. Decedent's Name (First Eleano | | | Hanlor | | | | | | 2. Date of De | | 2012 | 3. Time of Death 3:45 am |
| (| | Medic Examin | | 4a. Facility Name (if not in. | | | | · | 4b. Cit | y, Town, or | r Location nium | of Death | | 4c. Coun | ty of Death | re |
| | | Funeral Director | | 5. Social Security Number 295–18–9386 | 1 🗆 1 | и 2 Х F | 7. Age (In yr. 90 | s. last birthday Yrs. |) If Und Month | ler 1 Year s Days | If Under Hours | Min. | 8. Date of Bir 0°C t 26 | th y, Year 921 | g. Birthp | olace (State or Foreign try) 10 |
| | | aryland a-f show ified at | ector | Usual Residence of Deci 10a. State 10b. | County Baltimo | re | 10c. | City, Town or | Location nium | ! | <u> </u> | .] | | | 1 | 0d. Inside City Limits 1 ☐ Yes 2 🗶 No |
| | | with the M 23a or 28 ust be noti | Funeral Director | 10e. Street and Number 2525 Pot S | pring Rd | 1., # | L408 | | 10f. Z | Zip Code | 093 | | | 10g. Citizen o | f What Cour | ntry? |
| a.m. | 215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 호 | 11. Marital Status 1 ☐ Never Married 2 3 ☒ Widowed 4 ☐ □ | ☐ Married | . Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da | edent Ever in rces? 2 X No | | If Yes, sp | ecify Cuba | Specify | n, Puerto | cify Yes or No- Rican, etc.) | | ace - Americ ack, White, of | |
| 3:45 | 21215- | within 72 ho giene. er than "nal , the Medic." | Completed | | Decedent's Education of the Decedent's Education of the Deceder of | | | (Giv | cedent's Us re kind of w DO NOT u nemake | ork done (se retired) | during mos | st of worki | ng | 16b. Kind of | Business/Ind | |
| 2012 | Maryland | ld be filed Mental Hy arked oth atic event | To Be | 17. Father's Name (First, M | Aiddle, Last) | Tra | ірр | | | | | ner's Name nily | e (First, Middle, | Maiden Surnar Sa | ne) aul | |
| 17, | , Mar | ad 2 shoul ealth and m 27 is m | | 19a. Informant's Name/Re Philip Hanl | on-son | Print) | | | | | | | | er, City or Town, | | |
| JARY | altimore, | Page 1 a ment of H ant: If ite ury or oth | | 20a. Method of Dispositio 1 ☐ Burial 2 🛣 Cre 4 ☐ Donation 5 ☐ | mation 3 Re | | State | b. Place of Dis cemetery, ci Hilltop | rematory or | r other plac | p p | | 0/12 | 20c. Location | n - City or To | |
| FEBRUARY | Balt | permit Depart Import any inj | | 21. Signature of Funeral S | | | | | 1050 |) Yor | k Rd. | . , To | wson, M | 1D 2120 | | me, Inc. |
| | | medican Medical Examiner | | 23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death) | ease, or complicate. List only one c | SEPS | ich line. | | nter the mo | ode of dyir | ig, such as | s cardiac c | r respiratory ar | rest, | - | Approximate Interval Between Onset and Death |
| 20- | | ate be executed physician and the burial-transit | dical Examiner | Sequentially list condition if any, leading to immedia cause, enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | ns, b. | | (or as a cons | | | | | | | | | |
| コナナ | Box 68760 | Attending Physician: The law requires that the death certificate death. sctor: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the | Physician/Medi | IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 ☐ Yes 2 🗶 No 9 ☐ Unknown | anı | 1 Live | nant at time | etal death 3 | 3 ☐ Ectopi 5 ☐ Other | c pregnand (specify) _ | су | | | | Date of delive | ery Day Year |
| WALKS. | s, P.O. | ires that th signed by Id be detad | by | Part II. Other significant | conditions contr | ibuting to d | leath but not | resulting in th | e underlyin | g cause gi | ven in Par | t I. | | | | ne cause of death? bably 4 👿 Unknown |
| ELEANOR | Record | The law requate has beer page 2 shou | Completed | | | | | | | | | | | an 24b psy ormed? 2 X No | o. Were auto prior to co death? 1 ☐ Yes | psy findings available mpletion of cause of 2 \(\square\$ No |
| EL | Vital | Physician: The this certificate al director, pag | To Be | 25. Was case referred to r examiner? 1 ☐ Yes 2 😿 No | | pital: | Inpatient 2 | ☐ ER/Outpat | ient 3 🗌 | Oth | lace of De | | | dence 6 🗶 O | ther (Specify | HOSPICE |
| | Division of | or the Hospital or Attending Physician: within 24 hours after death as a fine furner or To the Funeral Director. After this certific completely filled in by the funeral director, | Certificate: | 2 Accident | Pending Investigation Could not be determined | 28e. Place | th, Day, Year, of Injury - A | t home, farm, | / M | 1 | y at | | 28d. Describe i | how injury occu | ırred | Route Number, |
| | Divi | the Hospital or Attendhin 24 hours after deat the Euneral Director: The Felled in by the | | 29a. Certifier 1 ☐ C | ertifying Physicia | an: To the b | ng, etc. (Spe | iowledge, deat | h occurred | at the tim | e, date an | d place, a | City or To | ause(s) and ma | nner as stat | ed. |
| | _ | To the Hos within 24 h To the Fun completely | Medical | (Check 2 M | edical Examiner ertifying Nurse P | : On the bas | sis of examina | ation and/or inv | estigation, ge, death o | in my opini ccurred at 9c. Licens | on, death o the time, d e number | occurred at | the time, date | and place, and c | due to the car d manner as | use(s) and manner state stated. |
| 4 | | | | 30. Name and address of JUNECIA W | | | | tem 23a) (Type | | EY RI | | IMONI | UM, MD | 21093 | 14/1 | 16 |
| | | Sta Registr | | 31. Date filed (Month, Day | Year) | 32. F | Registrar's S | nature | 4 | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Higgins, Jr. Physician/ John Arnold 16, 3:40 p M February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore Examiner 4b. City, Town, or Location of Death Parkville Oak Crest Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov 21, 1917 Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. 1 X M 2 🗆 F 94 Months Hours Maryland 216-07-0932 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore Phoenix 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2930 Paper Mill 21131 Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: '43-'45 White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Driver/Salesman Brewery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Higgins, Sr. Arnold Sadye McNally 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard T. Higgins-son 2930 Paper Mill Rd., Phoenix, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Parkwood Cemetery 1 X Burial 2 Cremation 3 Removal from State 2/21/12 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of). Cause (Disease or impury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown primonaly 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Higgins, Other autopsy death? 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number monic 058646 2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bou levaro 8800 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

FEB 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 04838 State of Maryland / Department of Health and Mental Hygiene

| Jessica Patrice Isa | | S For State | St | ate of Ma | aryland | - | tment of ficate of | | d Mental F | | | | - 0400 | |
|---|-------------|---|-------------------|-----------------|---------------------|---------------------------|-----------------------|-------------------------------|---|---|-----------------|-----------------|---|--|
| Physician | _ | e gistrar . Decedent's Nam | e (First, Midd | le,Last) | | | nouto or i | | · · · · · · · · · · · · · · · · · · · | 2. Date of Dea | | v | 3. Time of Death | |
| Medical Examine | | Je | SSICA | Pa | trice | , 7 | SAAC | <u>چ</u> | | Month February | | Year | 1510 hrs | |
| | 4 | a. Facility Name (i | | - | |) | 4t | . City, Town, or Baltimore | r Location of Deat | h | 4c. Co | unty of Death | | |
| Funeral | 5 | . Social Security N | | 6. Sex | | ge (In yrs. last | t birthday) | If Under 1 Yea | ar If Under 24Hr | s. 8. Date of Bi | irth (MM/DD/) | | hplace (State or | |
| Director | 1 | 115-25- | 1172 | 1 M 2 | √f F | 26 | Yrs. | Months Day | s Hours Mir | 2-12 | -190 | Foreig | in untry) /// / | |
| | _ | Isual Residence o | | | | | | | | 19.70 | | | 7,70 | |
| w any | Т | 0a. State | 10b. County | | | 10c. City, To | own or Locatio | n | | | | | 10d. Inside City Limits 1 Yes 2 No | |
| Maryland 28a-f show d at once | ĮĻ | 0e. Street and Nu | Da | 14 mor | . e | 0 | Edge | nere | | | 10a Citizen | of What Cour | | |
| the Maryland a or 28a-f sho tified at once. | [] | 9120 | _ | NUC. | R | | | -2 / | 219 | | | KSA | • | |
| | | 1. Marital Status | | 12. W | | t Ever in U.S. | | Decedent of Hi | spanic Origin? (S | | o- 14. i | Race - Ameri | can Indian, Black, | |
| r death with or items 23 : must be no | <u> </u> | 1 Never Marri | | 1 | | No | | -/ | n, Mexican, Puerto | o Rican, etc.) | | White, etc. | 1. | |
| s after ral", niner by I | 3 | 3 Widowed 15. Decedent's Ed | | orced If Yes, G | s: | moleted) 1 | | res 2 YNC | specify: ation (Give kind of | work done | Spe | of Business/I | ndustry | |
| 5-0036 ed within 72 hours at tygiene. other than "natural the Medical Examin | $\{ \vdash$ | Elementary/Seco | | | lege (1-4 or | | during mos | st of working life | e. DO NOT use re | tired) | | or Businessii | riduotiy | |
| 5-0036 led within 72 Hygiene. other than the Medical | | 12 | | | 2 + | | Adi | MINIST | RAHON 18.Mother's Nam | | Ac | COUNT | ING | |
| ID 21215-00; should be filed with and Mental Hygiene. 7 is marked other that event, the Med To Be Com | 3 7 | 7. Father's Name | | | C | | | | 18.Mother's Nam | e (First, Middle, | | name) | | |
| 2121 ould be fill d Mental H s marked tic event, | | 9a. Informant's Na | | SAACS | $\frac{1}{2}$ | | 19b. Mailing | Address (Stre | Leon. | Rural Route Number, City or Town, State, Zip Code) Gemere, NO 2/2/9 Date 20c. Location - City or Town, State | | | | |
| | i | LEONA | TSH | ACS-1 | KOth | eR. | | Avenue | - | | | | | |
| ore, MC s: land 2 si of Health au If item 27 | | 0a. Method of Dis | | 3 Rem | | 20b. Pla | | on (Name of ce | | Date | 20c. Loca | tion - City or | Town, State | |
| Pages nent of the orter of the orter of the orter or other | | | Other S | | iovai irom Si | 1 | IVIEW C | remato | RU 2/ | 16/2012 | Ba | Himor | ee, M) | |
| Baltimore, M permit. Pages 1 and 2 Department of Health Important: If iten 2 injury or other traus | 2 | 1. Signature of Fu | neral Service | Licensee | | | 22. Na | me and Addres | s Facility B | radley. | - ASL | TON FU | weral | |
| | 12 | 3a, Part I. Enter th | e disease or | complications | that caused | the death D | o not enter the | me Pl | 4, 2134 Such as cardiac | or respiratory ar | rest, shock, o | r heart | Approximate Interval | |
| Physician Medical | Į | failure. List on | ly one cause | on each line. | | | | | , | , | , , , , , , , , | | Between Onset and Death | |
| Examiner | | mmediate Cause (or condition resulti | | | | equence of): | ication | | | | | | | |
| | | Sequentially list co | | b | | | | | | | | | | |
| | | f any, leading to in cause. Enter Under Disease or injury t | erlying Cause | | or as a cons | equence of): | | | | | | | | |
| red nsit Examiner | 1 | events resulting in | | Due to (| or as a cons | equence of): | | | | | | | | |
| Box 68760, re death certificate be executed the attending physician and red for use as the burial - transi thysician/Medical Ex | | X UNPENDED | | d | IDED 23a | .27.28 | a-f.pe | me.29 | 26 4-12- | 12 sm | | | | |
| 60, ate be: hysicia c buria | | F FEMALE: | | | | me of pregna | | 76- | | | 23d, Da | ite of delivery | , | |
| 68760, crtificate b ding physics e as the bu | 23 | Bb. Was decedent past 12 months | | ne 1 | Live birth | t time of deatl | | I death 3 | Ectopic pregn | ancy | Mor | nth D | Day Year | |
| h. Box 68760 the death certificate by the attending physiched for use as the bursician/Met | | 1 Yes 2 1 | √o 9 🗹 Un | known 9 | Unknown | t time of acat | '' 5 Othe | er (Specify) | | | | | | |
| Records, P.O. Box 68760 The law requires that the death certificate b icate has been signed by the attending physipage 2 should be detached for use as the bucompleted by Physician/Me | | Part II. Other signi | ficant condi | tions contrib | uting to deat | th but not resu | ulting in the un | derlying cause | given in Part I. | | | | the cause of death? | |
| s, P.O. irres that the signed by the detach | | | | | | _ | | | | | | | pably 4 🗸 Unknown | |
| cords, law requir has been s 2 should | | | | | | | | | | 24a, Was | | | topsy findings available completion of cause of | |
| tal Records, clan: The law requires certificate has been signetion, page 2 should be Ba Completed | | | | | | | | | | 1 Yes | | 1 Ye | es 2 No | |
| Sector Sector | 3 2 | 5. Was case refer examiner? | | l Hospital: | 1 Inpati | ont 2 A | R/Outpatient | | e of Death (Check Other 4 Nursi | | Residence | 6 Other | | |
| 1 Of Vit ling Physic After this funeral dire | 12 | 1 Yes 7. Manner of Dear | No No | 28a | a. Date of Inj | ury 2 | 28b. Time of Inj | | ury at Work? | 28d. Describe | | | - | |
| Sion (Attending death. cetor: Ad the fur | | 1 Natural 2 Accident | 5 Pen | ding f o | (Month, Day, d 2-12 | 2-12 | Fd 1420 | hrs 1 | Yes 2 X No | unknowi | 1 | | | |
| Division o spital or Attending tours after death. neral Director: Aft filled in by the fune Certification: | | 3 Suicide | 6 X Cou | ld not be | | | | factory, office | building, etc. | | | | ral Route Number, City oln Ave. | |
| Spital spital hours a refilled y filled | 5 2 | 4 Homicide | | | | Resider | | | | Sparrov | <u>vs Poir</u> | nt.MD. | | |
| Division To the Bospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the Medical Certificati | 3 6 | Check only ' 📖 | | miner:On the | basis of exa | | | | late and place, an n, death occurred | | | | | |
| To with | 2 | 9b. Signature and | title of certific | | anner stated | .71 | 10 | 29c, Licen | se number | | 29d. Date | signed (Mor | nth, Day, Year) | |
| | ı | 6/1 | 11 | 1 | 1 | 154 | 76 | 0.0 | .M.E. | | Februa | ry 13, 201 | 2 | |
| | 3 | 0. Name and add | | | | | | li c | - 1 D - 101 | MD 04005 | | | | |
| | | Zabiullah A | | Assistant N | | xaminer ar's Signature | | utimore Stre | eet, Baltimore | , мо 21223 | | | <u> </u> | |
| Stat Registra | ~ | Date liled (MON | ui, Day, Year) | 112 | S. Negistia | 5 Signature | 1:4 | A. | | | | | | |
| DHMH 17 Rev 1/2001 | _ | ret | 212 | 112 / | CARLO. | p. | ORIGINAL | | | | | | OCME | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ eb Ver 3:50 A Walter D. Isennock Jr. Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Hospital Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 217-50-6822 1 M 2 🗆 F Director 63 April 19,1948 | Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Marviand Director notified MD Glen Burnie 1 X Yes 2 □ No Anne Arundel 28a-f 10e. Street and Numbe 10f. Zip Code 6 10g. Citizen of What Country? must be Funeral 23a with 1914 Norwich Road 21061 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No Army
If Yes, Give
Year or Dates 1970–1974 Black White, etc 0 þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Transportation Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H f item 27 is marked ot r other traumatic even ည Mary Jane Hudler Walter D. Isennock Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Mary Isennock / Wife 1914 Norwich Rd Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or Department of Important: If any injury or ICCI Chesapeake Crematory 2/22/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services P.O. Box 1413 Baltimore, MD 21203 Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each ne. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes been Were autopsy findings available prior to completion of cause of death? Was al. autopsy performed? Yes 20 No 24a. Was an has page 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of De 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 2012 10:25 P M EILEEN **JANUARY** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MORNINGSIDE HOUSE OF FRIENDSHIP ANNE ARUNDEL HANOVER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Days Hours (Month, Day, Year) 576.40.6779 Months 1 - M 2 XXF **Director** 86 DEC 6, 1925 UNITED KINGDOM Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland must be notified at Director 1 Yes 2 No MD ANNE ARUNDEL HANOVER 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7548 OLD TELEGRAPH RD. USA 21076 ral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XXWidowed 4 \(\subseteq \text{ Divorced} \) Specify: "natural" Completed WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working if Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be WILLIAM BUCKLEY JOSEPHINE LYONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a MARY SIDDALL 754 ELMHURST RD. SEVERN, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 XX Cremation 3 Removal from State cemetery, crematory or other place) ō Department Important: I any injury or BAYVIEW CREMATORY INC FEB 17, 2012 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signatur Fun rei Trum Live see C FANK PONERALES HOME Ility P.A. M01148 426 CRAIN HWY SW GLEN BURNIE, MD21061 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on explane. Ret and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or I that initiated events and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 mo Year Pregnant at time of death Month Day be detached Yes 2 No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has build be continued in the continued in autopsy performed Yes 2 No 1 Yes 2 40 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. (Month, Day, Year) 5 Pending atural work? 1 D Yes 2 No Accident Investigation filled in by the 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) who completed cause of death (Item 23a) (Type, Print) 32. Redistr State Registrar

DHMH 17 Rev 06-2011

for State Registrar

Myrna

Physician/

Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

216-34-3331

4a. Facility Name (if not institution, give street and number)

PSOITAL

1 🗆 M 🔏 F

| 5 | | aryland a-f show fied at | Director | 10a. State MD | 10b. County NA | | | vn or Location | ; | | |
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| ארמלי | | with the Mi 23a or 28 ust be noti | Funeral Dire | 10e. Street and Nun | | ve | | 10f. Zip | Code 2120 |)7 | |
| ones, myrna | 980 | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | þ | 11. Marital Status 1 ☐ Never Marri 3 【XWidowed | ed 2 Married | 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates. | | If Yes, spec | lent of Hispanic ify Cuban, Mexi 2 X No S <i>p</i> ec | ican, Puerto | ecify Yes or N Rican, etc.) |
| 3000 | Baltimore, Maryland 21215-0036 | ithin 72 hour ene. • than "natu the Medical | Completed | (Spe | 15. Decedent's E cify only highest gr andary (0-12) | ducation ade completed) College (1-4 or 5 | | a. Decedent's Usua (Give kind of wor life. DO NOT use Manage | k done during n retired) | nost of worki | ing |
| 7 : 30 | /land 2 | d be filed w Mental Hygi arked othe atic event, 1 | Be c | 17. Father's Name (I | First, Middle, Last) ay | | | | Doi | other's Name | Merc |
| Lubba C | e, Mary | and 2 shoul Health and I em 27 is ma ther trauma | | 19a. Informant's Na Montrae 20a. Method of Disp | | ^(ype, Print) Gra Lee-Dau | _ | | | 1 | |
| r Kno | altimor | t. Page tment c tant: If jury or | | 1 💢 Burial 2 | Cremation 3 5 Other (Speci | - | cemet | of Disposition (Namer, crematory or of Son For 22. Name an | rest | 2/22 | Date 2/2012 |
| 3 | B | permii Depar Impor any in | | Ja | mon | Mai | ham | | d Address of Fa | | |
| 2 | | Physician/ Medical | | shock, or heal Immediate Cause (disease or condition resulting in death) | t failure. List only c Final | plications that caused one cause on each line a. A Due to for as a | a consequence | ocard | ial I | nfar | ctio |
| | | Examiner | iner | Secure tially list to if any, leading to in cause. Enter Under | mediate | Coron | ^ | etery i |)isca | 8¢ | |
| | 00 | e be executec ysician and ne burial-trans | lical Examiner | Cause (Disease or that initiated events resulting in death) I | injury s | c. Due to (or as a | a consequence | Umones e of): | y H | PER. | tens |
| | Records, P.O. Box 68760 | The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown | months? | 23c. If yes, outcome 1 | 2 Fetal dea | | | | |
| | ds, P.O | quires that the signed by ould be deta | ted by Pl | Part II. Other signif | erters (| ontributing to death b | ut not resulting | g in the underlying o | cause given in P | art I. | 23e. Di |
| | ecor | ne law rec e has bec age 2 sho | Completed by | Dysl | ipidem | ia | | | | | 24a. W au 1 🗆 Y |
| | | ian: Ti rtificat ctor, p | Be C | 25. Was case referre examiner? | ed to medical | | | | 26. Place of I | Death (Chec) | |
| | Ξ | hysic this ce al dire | မှ | 1 🗆 Yes 2 🖺 | (V)o | | | Outpatient 3 D | | Nursing Ho | |
| | Division of Vital | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director, | Certificate: | 27. Manner of Death 1 Natural 2 Accident 3 Suicide | 5 Pending Investigatio 6 Could not be | | v, Year) | . Time of injury M | 8c. Injury at work? 1 Yes 2 | | 28d. Describ |
| | Divis | spital or A | | 4 Homicide 29a. Certifier 1 | determined | building, etc | c. (Specify) | | | and place, a | City or |
| | | To the Howithin 24 Post of the Furst Completely | Medical | (Check 2 | ☐ Medical Exam ☐ Certifying Nur | iner: On the basis of e se Practitioner: To th | xamination and | Vor investigation, in a owledge, death occ | my opinion, deat | h occurred at , date and pla | t the time, da |
| i | | | | 30. Name and add | eee of person who | completed cause of d | eath (Item 23a | | ES-0 | 00 | |
| | 5_ | Sta | te | 31. Date filed (Mont | DRA MA h, Day, Year) | 32. Registra | ar's Signature | CJINA | HI HOAA | Di Tal | 9 |
| . V | DH | Registra | | FEB 2 | L 2012 | Emma > 1 | for | 25 | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 2. Date of Death 3. Time of Death Day 8:APM February 13, 2012 4b. City, Town, or Location of Death 4c. County of Death 147 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. 20 33 MD 08 10d. Inside City Limits 1 🎇 Yes 2 □ No 10g. Citizen of What Country? U.S.A. No-14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Food Service dle, Maiden Surname) cer nber, City or Town, State Zip Code 207 20c. Location - City or Town, State Owings Mills, Md timore, Md 21215 Approximate Interval Between Onset and Death 23d. Date of delivery id tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? las an 1 ☐ Yes 2 ☐ No es 2 No esidence 6 Other (Specify) be how injury occurred on (Street and Number or Rural Route Number, Town, State) e cause(s) and manner as stated. ate and place, and due to the cause(s) and manner stated. to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2012

Certificate of Death

Months

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Baltimore

Hours

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | - | For State | State of Maryland / I | Department of H Certificate of D | | | | |
|----------------------------|---|-----------------|--|---|--|---------------------------|---|--|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Las | t) | Certificate of D | Catif | 2. Date of Deat | | 2 3. Time of Death , 2 |
| Н | Physicia Medic | | Mary | Pink | Jon | es | FEBT VA | | 2 1238049 |
| and the contract of | Examin | | 4a. Facility Name (if not institution, give | | 4b. City, Town, or | Location of Death | VIII | 4c. County of Dea | th |
| | Funeral | | 5. Social Security Number 6. Se | 7. Age (In yrs. last birt | thday) If Under 1 Year | If Under 24 Hrs. | 4.1 | g. Bir | thplace (State or Foreign |
| | Director | | 217-10 4220 | □ M 2X F 87 | Yrs. Months Days | Hours Min. | 8. Date of Birth (Month, Day, 02 27 | 24 Co | MD MD |
| | nd how at | ٦ | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Tow | n or Location | | | | 10d. Inside City Limits |
| | Aaryla 8a-f s tified | Director | MD NA | Ba | ltimore | | | | 1 🔀 Yes 2 □ No |
| | th the ? 3a or 2 t be no | ral Di | 10e. Street and Number 4510 Fairfax Ro | nad 1st Floor | 10f. Zip Code | 1216 | | 10g. Citizen of What Co | ountry? |
| | eath w | Funeral | 11. Marital Status | 12. Was Decedent Ever in U.S. | 13. Was Decedent of His If Yes, specify Cubar | spanic Origin? (Spe | cify Yes or No- | 14. Race - Ame | |
| Maryland 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once. | by | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. | 1 Yes 2 X No | | Hican, etc.) | Black, Whit | Black |
| 15-0 | 72 hou "natu edical | Completed | 15. Decedent's E (Specify only highest gra | | Decedent's Usual Occupa (Give kind of work done d | | ng | 16b. Kind of Business | Industry |
| 12. | vithin 7 iene. | | Elementary/Seconday (0-12) 8th grade | College (1-4 or 5+) na | Homemaker | | | Home | 9 |
| nd | filed val Hyg d othe | Be c | 17. Father's Name (First, Middle, Last) | · · · · · · · · · · · · · · · · · · · | | 18. Mother's Name | | Maiden Surname) | |
| ryla | uld be I Ment narke | P | Lloyd Kay | 2:4 | | | | O" T 0' - 7 | in Ondah |
| Ma | 12 sho alth and 27 is r | | 19a. Informant's Name/Relationship (T) Betty Atkinson | | b. Mailing Address (Street a 1515 Forest | : Park A | ve, Ba | ltimore, | Md 21216 |
| Baltimore, | ge 1 and it of Hea If item or othe | | 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 | Removal from State cemete | of Disposition (Name of ery, crematory or other place | e) | Date 12012 | 20c. Location - City o | r Town, State |
| ltim | nit. Pagartmen ortant: injury | | 4 ☐ Donation 5 ☐ Other (Specification of Funeral Service License) | | son Forest | | /2012 | | |
| Ba | Depar Impor any in | | > Myni | 13 Keke | Marsand Address Name and Name a | | | · | 21215 |
| | | | 23a. Part 1. Enter the disease, or com shock, or heart failure. List only o | | | | | | Approximate Interval Between Onset and Death |
| | Physician Medical | | Immediate Cause (Final disease or condition resulting in death) | a. ATherosci Due to (or as a consequence | | Teaper | visea | s E | Oriset and Boarn |
| Name of Street | Examiner | | f | Due to for as a consequence | | | | | |
| | p ## | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequence | of): | | | | |
| | ate be executed physician and the burial-transit | Exan | Cause (Disease or linjury that initiated events resulting in death) Last | cDue to (or as a consequence | of): | | | | |
| 0 | e be ey ysiciar e buria | lical | L L | d | | | | <u> </u> | |
| 68760 | rtificate ing phy e as th | | IF FEMALE: | 02+ Hugo otherms of programs. | | | | | |
| Вох 6 | ath ce attend for us | Physician/M | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death | th 3 Ectopic pregnand 5 Other (specify) | СУ | | 23d. Date of d | elivery Day Year |
|). B | the de by the ached | hysi | 1 Yes 2 No g Unknown | g 🗌 Unknown | | | | | |
| s, P.O. | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | Completed by F | Part II. Other significant conditions of Hypertension | | in the underlying cause giv | ven in Part I. | | bacco use contribute t ∕es 2 □ No 3 □ I | Probably 4 Unknown |
| ord | w requisite been 2 should | plete | | | | | 24a. Was a | | utopsy findings available completion of cause of |
| Rec | The la | Com | | | | | perfor | med? death? | |
| ital | ician: certific rector, | Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | Othe | ace of Death (Chec er: | | - T | |
| of V | g Physer this er this eral di | e: 70 | 27. Manner of Death | 1 Inpatient 2 XER/C 28a. Date of injury (Month, Day, Year) | Time of 28c. Injury | y at | | ence 6 Other (Spe ow injury occurred | icity) |
| lon | eath. or: Aft the fur | Certificate: | Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be | | M 1 🗆 | Yes 2 ☐ No | _ | | |
| Division of Vital Records, | l or Att | Cert | 4 ☐ Homicide determined | 28e. Place of Injury - At home, f building, etc. (Specify) | arm, street, factory, office | | 28f. Location (S City or Tow | treet and Number or R n, State) | urai Houte Number, |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has a completed filled in by the funeral director, page 2 | Medical | (Check 2 Medical Exam | sician: To the best of my knowledge iner: On the basis of examination and | or investigation, in my opinion | on, death occurred a | t the time, date a | nd place, and due to the | e cause(s) and manner stated. |
| | To the within to the To the comple | Σ | only one) 3 L Certifying Nur 29b. Signature and title of certifier | se Practioner: To the best of my know | wiedge, death occurred at th | | | 29d. Date signed (Mon | |
| | | | 1 med 6 | - MD | 200 | 24228 | | Februari | 16,2012 |
| 2 | r | | 30. Name and address of person who | completed cause of death (Item 23a) | JE MD | SINA | I Ho | SOITAL A | of BAltimore |
| | Sta Registr | | 31. Date filed (Month, Day Year) FEB 2 1 2012 | 32. Regist ar's Signature | | | | * | |
| | negisti | वा | /- | | | | | | |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 21, 2012 Dolores Mary Kidd 8:00 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 10141 Charington Road Cockeysville Baltimore County 5. Social Security Number 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1 🗆 M 2🗶 F Hours 213-20-4705 Baltimore, MD **Director** 85 June 06,1926 Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore County Cockeysville 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10q. Citizen of What Country? Funeral , or items 23a 10141 Charington Road 21030 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", White 3 ₺ Widowed 4 □ Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **02** Office Manager Office Management 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Bernard Williams, Sr. Theresa Anna Schleicher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mr.Michael John Kidd 10141 Charington Road Cockeysville, MD. 27 21030 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once, Location - City or Town, State (**Harford County)** 1
Burial 2 Cremation 3
Removal from State remetery, crematory or other place)
Fwans Funeral Cremel and
Cremetion Services, Inc. Wednesday Feb. 22, 2012 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Segrice Licensed of Funeral Segrice Licensed of Funeral Adverses of Familia Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 Part 1. Enter the disease of shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest st only one cause of such line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events use as the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Pregnant at time of death 5 Other (specify) Month Dav Year detached g Unknow 9 Unknown n signed by t. Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Inknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 Tyes 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home After this Residence 6 Other (Specify, Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work 1 🗆 Yes 2 🗆 No Accident Investigation after death Director: / Suicide 6 Could not be Location (Street and Number or Rural Route Number City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29b. Signature and title of certifier 29d. Date signed (Month), Day Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Meltzer, M.D. 16918 York Road Suite 100 Hereford, Maryland 21111 2 1 2012 State FEB Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month February 2012 Year Physician/ 12:50 A Theodore C. Kenny, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A 623 West 36th Street Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 215-30-4201 Director **X**X M 2 □ F MD 78 Nov 24,1933 Yrs. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location aţ 10a. State Director notified MD 1 XX/es 2 No N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Examiner must be items 23a Funeral 21211 U.S.A. 623 West 36th Street death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ed Forces Black, White, etc. 1 XXYes 2 No 1 Never Married 2 Married "natural", or by Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: Specify: White Year or Dates. 58-62 3 ₩Widowed 4 □ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Railroad ge 1 and 2 should be filed within 73 to f Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me ementary/Secondary (0-12) College (1-4 or 5+) 12th --Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Kenny မ Marie Hubbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 623 West 36th Street Baltimore, Maryland 21211 Theodore C. Kenny, Jr. (Son) 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Department of Important: If it any injury or o Parkville, MD Parkwood Cemetery 2/23/2012 Donation 5 Other (Specify) 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. Balto,MD 21211 3<u>631 Falls Road</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage disease or condition Medical resulting in death) Due to (or as a conseque e of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events Lensio and Due to gras a consequence of): resulting in death) Last attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the at d be detached for Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform has death?
1 Yes 2 No I or Attending Physician: The after death.

Director: After this certificate by 1 Yes 2 W/No 25. Was case referre o medical filled in by the funeral director, 26. Place of Death (Check only one) Be 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) 27. Manne of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury $5 \square$ Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌

State Registrar

29b. Signature and tile of

31. Date filed (Month, Day, Year)

Heartland Hospice

32. Re

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HEartland Hospica, 4 East Rolling Conscrads, Suite 307, Bashmore MD 21228

H 46961

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frances Kincer Feb. 1.3Day 2012 10:35A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Co. 8126 North Boundry Road Dundalk 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. (Month 214-26-6065 **Director** Aprill0,1922 Virginia Usual Residence of Decedent 28a-f shov or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a United States 8126 North Boundry Road 21222 items ? 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give White 3 Widowed 4 □ Divorced "natural", Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 in and Mental Hygiene.
7 is marked other than "1 Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Atha E. Duncan Wiley J. Eanes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 2428 Fairway Oaks Court Hampstead, MD 21074 Tammy Shipley (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury Hilltop Service Corp. 2/15/2012 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. any 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disperse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner work Sequentially list conditions. cause. (Disease or linjury Examine Due to for as a co s uence of physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as t nding p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown in the past 12 months? for Day 5 Other (specify) Pregnant at time of death 2 No the 9 Unknown been signed by t should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ م To the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available certificate has prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy perform 2 0 Yes 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner 2 📑 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie ne and address of person who completed cause of death (Item 23a) (Type, Print) U East Mach Street HUJ ZIK MA TIM

State Registrar 31. Date filed (Month, Day, Year)

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:30 p M Adolphe G. Koppel February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Emeritus of Towson Towson Baltimore If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Hours 214-16-3334 Director 90 1**X** M 2 □ F 8 1921 South Carolina Dec. shov 10a. State 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Sheridan Avenue 1238 21239 U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Examiner Armed Forces? Black, White, etc. ŏ ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1941-45 1 ☐ Yes 2 XNo Specify. Specify: White "natural". 3 N Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rtal Hygiene. ed other than " College (1-4 or 5+) Elementary/Secendary (0-12) Mariner Merchant Marine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ith and Mental F 27 is marked of traumatic even ဂ္ Aron Koppel Edna Gottwalles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Timonium, Maryland Robert Koppel / Son 554 Kinsale Road t: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or 2/17/2012 HilltopServiceCorp. Towson, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Signature 22. Name and Address of Facility Ruck Towson Funeral Home. 1050 York road, Towson, Maryland sations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dealentia Carc disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-tra Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 as the IE FEMALE asn f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death g Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 s autopsy performed' 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other:
4 Nursing Home 5 Residence 6 Other (Specify) FACILITY 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation. Medical within 24 hou

To the Fune

completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur 29d. Date signed (Month, Day, Year) 2012 cause of death (Item 23a) (Type, Print)
(W) 6701 N (Charles ST Towson) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19, February 2012 Jerome W. Kinnear 12:15 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) (Month, Day, Year) Hours Director 1**X X**M 2 □ F 215-18-5106 90 9/4/1921 Maryland 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County at Director must be notified Baltimore Maryland Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2525 Pot Spring Road 21093 U.S.A. # 318 12. Was Decedent Ever in U.S. Armed Forces?

1XXYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: "natural", 3 ₩ Widowed 4 □ Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Draftsman Chemicals any injury or other traumatic event, אינט ב should be filed cepartment of Health and Mental Hy, Important: If item 27 is marked any injury or ceiver. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mable Fields John H. Kinnear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Popp / Nephew 7 Hunters Court Timonium, Maryland 21093 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State FEBRUARY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp 2/21/2012 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. . Signature 1 M 1050 York Road Towson, Maryland 21204 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician a the burial Physician/Medical Records, P.O. Box 68760 as attending p IF FEMALE JEROME KINNEAR ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Ectopic pregnancy Month Year Pregnant at time of death Other (specify) the a g Unknown I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ. 4 Unknown 1 Yes 2 No 3 Probably Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 1 Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Accident 2 Accider
3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 20 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State FEB 2 1 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 **1 –** For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2012 11:25 AM L1oyd Ira Laing Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Gilchrist Hospice Care Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 191-14-8690 1 XM 2 □ F April 21,1923 88 PA Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2 X No MD Baltimore Towson 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be i Funeral 7925 York Road 21204 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Ⅸ Yes 2 □ No
If Yes, Give Year or Dates. 43-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕅 No Specify: Completed 3 Widowed 4 Divorced Il Hygiene. I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A Steel Worker Bethleham Steel Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, tlonce. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Alfred Laing Henry Annie Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7925 York Road #105 Margaret K. Laing/Wife Towson, MD 21204 20a. Method of Disposition Date 21 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Feb. 4 Donation 5 Other (Specify) Atlantic Crematory 2012 Glen Burnie, MD . Signature of Funeral Service Vicen 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Inc. Flagle 23a. Part 1. Softer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Bowe OBSTRUCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has filled in by the funeral director, page 2 performe this certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify HOSPICE ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 Pending 1 -Natural work?
1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Erin Crawford Lang | _ | D04-4a | St | ate o | f Maryla | nd / De | | | | and | Menta | ΪНуς | giene | | 2.0 | 1 1 / | 2 0 | 1 01 |
|--|----------|---|-------------------------------|----------------------|--------------------------|--------------------------------|--|----------------------|-------------------------------|----------------------|----------------------------|--------------------|--|------------------------|-------------------------|---------------------|----------------|----------------------------|
| | R | - For State Registrar 1. Decedent's Name | ~ (Eiret Midd | a Last) | | C | ertificat | te ot | Death | | | 12 | . Date of De | Reg. No. | <u> </u> | | 3. Time of | 484 Pooth |
| Physician Medical Examine | , | 1 | 2RAU | | RD / | ANG | E | | | | | | Month February | 8, 2012 | | | 1610 h | |
| | 4 | 4a. Facility Name (i 920 St. Cha | | , 0 | treet and nu | mber) | | 4 | b. City, Tow Arbutus | , | ocation of D | eath | | | County of altimore | | nty | |
| Funeral | 1 | 5. Social Security N | lumber | 6. Sex | | 7. Age (In yrs | s. last birthd | lay) | If Under 1 | Year Days | If Under 2 | 4Hrs. Min. | 8. Date of B | | | 9. Birth Foreign | | te or A Sh |
| Director | _ | 401-94-C | | 1 M | 2 F | | 49 | Yrs. | Months | Days | Tiodis | IVIAI I. | 6-1 | 6-6 | 2 | | intry) D | .C. |
| /any | | 10a. State | 10b. County | | | 10c. C | ity, Town or | Locatio | n | | | | | | | | | City Limits |
| yland -f show | <u>.</u> | 10e, Street and Nur | BALT | MC | DRE | | | AK | 2 <u>多い</u> | 10 | 15_ | | | 10g. Citize | on of Mhai | t Cause | | 2 No |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f show imatic event, the Medical Examiner must be notified at once. TO Be Completed by Funeral Director | | 920 <i>S</i> A1 | | باهم | =c 1 | 15 | | | 7 | しつ | 79 | | | rog. Citize | U . | 5. | A· | |
| death with or items 23 must be no | 6 | 11. Marital Status 1 Never Marrie | _/ | . 1 | | edent Ever in | U.S. 1 | 3. Was | Decedent of | of Hispa | nic Origin? Mexican, Pu | (Spec | cify Yes or N | 0- 1 | 4. Race - | | an Indian, i | Black, |
| ter deat ", or it er mus | | 3 Widowed | | 1 | 1 Yes Yes, Give Year | 2 No | , | _ | Yes 2 | | | | , ., | s | specify: | . 1 | 415 | _ |
| nours after a stanting the samine | | 15. Decedent's Ed | lucation (Spe | cify only | r Dates: highest grad | le completed) | 16a. De | cedent' | s Usual Occ | cupatio | n (Give kind | | vork done 16b. Kind of Business/Industry | | | | | |
| 5-0036 ed within 72 hour lygiene. other than "natta the Medical Exar Completed | 2 | Elementary/Seco | ndary (0-12) | | College (1 | -4 or 5+) | | | | | Salia | | -/ | U.S. GOVT. | | | | |
| 5-0036 led within 7 Hygiene. other than the Medica | 5 | 17. Father's Name (| First, Middle, | Last) | | | <u>u</u> | UKT | T 51 | | .Mother's N | lame (F | irst, Middle, | | | <u> 20</u> | V 1. | |
| 2121 Muld be fill Mental F marked c event, | | PAUL RUS | | | | D | 10h 1 | Mailing | Address (| Stroot a | | | rd Bouto Nu | | | | Zin Cada) | |
| AD 21 2 should h and Me 27 is ma matic or | | ERNEST C. | | | | dr As | 19b. Mailing Address (Street and Number or Rural Route Number, City or 1900 Sawt Charles Aye, Arbutus, Md. 2 | | | | | | | | | | Zip Code) | |
| 무현등 | 2 | 20a. Method of Disp | oosition Cremation | , | | 20 | b. Place of C crematory | Disposit | ion (Name d | of ceme | tery, | | Date | 20c. Lo | ocation - C | ity or T | own, State | 1 |
| timore, t. Pages la ment of He trant: Viu | | 4 Donation 5 | Other Sp | ecify: | | | I. ARUN | | REMA | HOP | N 2 | -12 | 2-12 OGNION, MID. CHERTY FUNERAL HOME | | | | | • |
| Balti permit. Departm Imports injury o | É | 21. Signature of Eur | neral Service | Sec | Man | DIVI- | e e | 22. Na | me and Add | dress o | Facility V | کالک کام | SNERT INEA 14 | | ・エリ | | OME | 8 |
| Physician | 2 | 23a. Part I, Enter the failure. List onl | | | | aused the dea | ath. Do not e | enter the | mode of d | ying, su | ich as cardi | ac or re | espiratory ar | 4 | | _ | | ate Interval Onset and |
| Examiner | | Immediate Cause (For condition resulting | | | | clerot | | rdio | vascu | ılar | Dise | ase | | | | -1 | | eath |
| | | Sequentially list cor | | b | | | | | | | | | | | | _ | | |
| ed nsit Examiner | | if any, leading to im rause Finter Under (Disease or injury th | rlying Cause | C. | ∍ to (or as a | consequence | e of): | | | | | | | | | | | |
| | | events resulting in o | | Due d. | ∍ to (or as a | consequence | e of): | | | | | | | | | | | |
| be executed be executed sician and urial - transi | | X UNPENDED | | | MENDED | 23a,27 | ,per | me,g | 3924 2 | 2-23 | -12 s | m | | | | | _ | |
| Box 68760 e death certificate I the attending phys ed for use as the bh | 23 | F FEMALE: 3b. Was decedent p past 12 months' | | | 23c. If yes, o | outcome of pro | egnancy 2 | Feta | il death | 3 | Ectopic pre | egnanc | у | | Date of de Ionth | elivery Da | ау | Year |
| Box 6876(e death certificate the attending phy ed for use as the the hysician/Ma | 5 I - | past 12 months 1 Yes 2 ✓ N | | nown | 4 Pregna | ant at time of | | Othe | er (Specify) | _ | | | | Î | | | | 1 |
| O. Bo at the de d by the stached f | - F | Part II. Other signif | icant conditi | | | death but no | t resulting in | the un | derlying cau | use giv | en in Part I. | | | | | | ne cause of | |
| Division of Vital Records, P.O. End or Attending Physician: The law requires that the draft each. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached artification: To Be Completed by Phraftication: To Be Completed by Phraftication: | | | | | | | _ | | | | | | | | | | ably 4 | |
| Cord law req has bee | | | | | | | | | | | | _ | 24a. Was auto perfo | | pric | | mpletion of | gs available f cause of |
| Record a: The law ru uificate has b or, page 2 sho | | 25. Was case referm | ed to medica | | | | | | 26.F | Place of | Death (Che | eck onl | | 2 No | 1 🗸 | / Yes | 2 [| No |
| Vital F nysician: this certifi I director, | | examiner? | 2 No | | pital: 1 Ir | npatient 2 | ER/Outp | atient | | | her ₄ Nu | | | Residence | ce 6 🗸 | Other: | Scene | - 1 |
| n of Vi ding Physian. After this funeral dir | | 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurre | | | | | | | | y occurred | | | | | | | | |
| IVISIOF or Attend after death Director: I in by the | | 2 Accident 3 Suicide | Inves | tigation d not be | 28e. Place | of Injury - At | home, farm | , street, | | | | | 3f. Location (| (Street and | Number | or Rura | al Route Nu | ımber, City |
| Division o spiral or Attending nours after death. neral Director: After filled in by the function: Certification: | | 4 Homicide | | mined | (Specify) | | | | | | | | or Town, | State) | | | | |
| Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Phyrician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physomophetely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me | | 29a. Certifier 1 (Check only 2) | Certifylng Ph Medical Exar | miner:Or | n the basis o | f examination | edge, death n and/or inve | occurre estigatio | ed at the tim n, in my opi | ie, date inion, d | and place, eath occurr | and du ed at th | e to the cau ne time, date | se(s) and and place | manner as e, and due | s stated to the | l. cause(s) | |
| S S S S S S S S S S S S S S S S S S S | 2 | 9b. Signature and I | itle of certifie | | nd manner st | ated. | - | | 29c. Lie | cense r | umber | | | 29d. Da | ate signed | (Mont | h, Day, Yea | ar) |
| | L | n ~ | بال | ` | | | | | 0 | .C.M. | E. | | | Febru | Jary 9, 2 | 2012 | | |
| | 3 | 0. Name and addre Donna M. Vi | | | - | e of death (Ite ledical Exa | | 900 V | V. Baltim | ore S | treet, Ba | ltimo | re, MD 2 | 1223 | | | | |
| State Registra | _ | 1. Date filed (Monti | h, Day, Year) | 201 | 2 32. Re | gistrar's Signa | ature 9. | pa | New? | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 11:52P M Biu ebruary Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death reater Baltimore Medical Center Baltimore Towson If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) Year If Under 24 Hrs. **Funeral** Months Min. Hours 215-47-2176 1 X M 2 □ F Director Sept. 3, 1947 64 Hong Kong Usual Residence of Deceden 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No MD Baltimore Owings Mills 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 17 Merino Ct. China 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. り、下午で þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Chinese 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Secondary (0-12) Jewlery Craftsman Jewlery and Mental Hygien Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lau Hing Ha Ching other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Owings Mills, MD Fong Lam/Wife 17 Merino Ct. 20b. Place of Disposition (Name of cemeter), crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Feb. ☐ Donation 5 ☐ Other (Specify) 2012 Timonium, MD 21. Signature of Fineral Cen 22 Name and Address of Facility Lemmon Funeral Home of Dulaney 10 W. Padonia Road Timonium, Dulaney Valley, Inc. imonium, MD 21093 09 Michael J. FLag1e Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Precumonia **Physician** disease or condition resulting in death) Medical **Examiner** cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a con: equence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) _____ 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Yes 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ပ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ours after death.

leral Director: Aff
filled in by the fur 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 24 hours a

To the Funeral C

completely filled 5 State Registrar

(Check

29b. Signature and title of certifier

FEB 2

31. Date filed (Month, Day

DHMH 17 Rev 06-2011

VENUTHA Chanday Hippure

ad at the time, date and place, and due t

0072682

29d. Date signed (Month, Day, Year)

6701 Northcharles St Toroson HD 21204

I Certifying Nurse Practitioner: To the best of my knowledge

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 19 William James Lee, S.S. 7:05 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore St. Martin's Home Baltimore 8. Date of Birth 5. Social Security Number 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days April 14, Months Hours Min **Director X** M 2 □ F Ohio 295-18-6656 89 1922 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Yes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a c c must b Funeral 601 Maiden Choice Lane USA 21228 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, th and Mental Hygiene. 27 is marked other than "natural", or iten traumatic event, the Medical Examiner i Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify White Specify. Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Roman Catholic Priest Church errit. Page 1 and 2 should be filed wi eg artment of Heatth and Mental Hygie Important: If item 27 is marked other ny injury or other traumatic event, ti on e. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Norbert Henry Lee Matilda Rose Sohl .67.6M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Very Rev. Thomas R. Ulshafer, S.S./Priest 5408 Roland Avenue Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sulpician Cemetery 2/25/12 Catonsville Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck Tinc 5305 Harford Road Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Due to or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) for in the past 12 months? Month Day Year Yes 2 No 9 🗌 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 Yes 2 No Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Wursing Home 5 Residence 6 Other (Specify filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hount of the completely file 29a. Certifier (Check Ceptifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title, ٥ 21649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

3455

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| | | | Pleas | se Type or | | | ndelible Ini artment of F | | - | | - | ible. | |
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| | - | For State Registrar | | State 0 | ı ıvıaryıa | _ | artment of F tificate of L | | i Wertai F | Reg. No | 00 | 12 | 01.052 |
| | | Decedent's Name | (First, Middle, i | Last) | | | | | 2. Date of Month | Death | | Year | 3. Time of Death |
| Physiciar Medica | | Ida May | | | | | | | Febr | | 17. | 2012 | 8:20 a ^M |
| Examine | r | 4a. Facility Name (if | | | | | 4b. City, Town, or | | ath | | . County | | |
| funeral f | | 5. Social Security Nu | | ke Medica | | last birthday) | Bel Ai | If Under 24 Hr | | Birth | Harf | 9. Birthpl | lace (State or Foreign |
| Director | | 215-01-93 | 379 | 1 □ M 2 🔀 F | 00 | Yrs. | Months Days | Hours Mir | , , , , | Day, Year) | ,, | Count | |
| d ti | _ | Usual Residence o | of Decedent 10b. County | | 99 | City, Town or Lo | cation | | Dec. | /, 19 | 12 | | yland Od. Inside City Limits |
| anylar ka-f sl | Director | Maryland | Harfo | Бn | | Air | | | | | | | 1 🗆 Yes 2 🔀 No |
| the N or 28 | | 10e. Street and Nurr | | Lu | 1061 | ALL | 10f. Zip Code | | | 10g. Ci | tizen of V | Vhat Count | ry? |
| h with 1s 23s nust b | Funeral | 131 Briarcliff Lane | | | | | 2101 | | | US | A | | |
| r deatl | F | 11. Marital Status | and O T Manusia | 12. Was Dece Armed For | ces? | J.S. 13. \ | Was Decedent of H f Yes, specify Cuba | ispanic Origin? (an, Mexican, Pue | Specify Yes or Narto Rican, etc.) | 0- | | e - America k, White, e | |
| s after | ed by | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. | | | | | 1 ☐ Yes 2 🛣 No | Specify: | | | Specify: | Whit | æ |
| hour "natu | blet | (Spec | 15. Decedent' | 's Education grade completed) | | 16a. Deced | dent's Usual Occup | ation during most of w | orkina | 16b. K | ind of Bu | siness/Ind | |
| thin 7% ene. than the Me | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) | | | | | O NOT use retired) | | | | | | |
| | Be (| 17. Father's Name (F | First, Middle, La | st) | | | Clerk | 18. Mother's N | ame (First, Mida | | nsur Surname | | |
| d be fi Mental arked rtic ev | 욘 | John Her | nry Fre | eburger | | | | Hatti | e May Si | nouff | er | | |
| shoull and l | | 19a. Informant's Na | me/Relationship | (Type, Print) | | | ng Address (Street | | | - | | | ode) |
| and 2 Health tem 27 | | Mary Pier 20a. Method of Disp | | ki / Daug | | 131 Place of Dispo | Briarcli | ff Lane | | | | 014 City or Tov | un Stata |
| Page 1 ment of 1 ant: If it | | 1 🛭 Burial 2 | Cremation 3 | Removal from | State | cemetery, cren | natory or other plac | | Date 21-12 | | | • | |
| 4 P T S | | 21. Signature of Fun | 5 Other (Sp. | | ITO | | rk Cemete | | | | THIOT | e, IV | aryland |
| Depar Impor any ir | | 21. Sign dury of Fune la Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 | | | | | | | | | | 9 | |
| | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between | |
| Physician/ Medical | | Immediate Cause (F disease or condition resulting in death) | | _a. Prol | salde | Acu | Te 51 | troke | | | | | Onset and Death |
| Examiner | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | ^ | | | | | Years |
| | ner | | | | | | | | | | | | 0. 0 |
| ecuted and -transit | Examiner | | | | | | | | | | | | |
| be executed ician and burial-transit | | | | | | | | | | | | | |
| cate be ex physician s the buris | Physician/Medical | | | d | | | | | | | | | |
| ath certifica attending p | <u>N</u> | IF FEMALE: 23b. Was decedent | pregnant | 23c. If yes, out | | | Totonio prognoso | | | | 23d. Dat | te of delive | ry |
| death | Sicie | in the past 12 months? 1 Yes 2 No 1 Pregnant at time of death 5 Other (specify) | | | | | | | | _ | Moi | nth | Day Year |
| es that the dea signed by the a be detached i | | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con | | | | | | | | use contr | ibute to the | e cause of death? | |
| ires th signe d be c | d by | Newto Renel Failure | | | | | | | | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown | | | |
| requires been sig should b | lete | | | | | | | | 24a. W | | 24b. V | Vere autop | sy findings available |
| he law te has bage 2 | Completed | | | <u> </u> | | | | | pe | topsy rformed? es 2 VN | | orior to con death? | npletion of cause of |
| sician: The lav certificate havilirector, page 2 | Be C | 25. Was case referre | d to medical | | | | | lace of Death (Ch | | | | | |
| Physic this ceral dire | ဂ | 1 Yes 2 2 | ₹No | Hospital: | | ER/Outpatier | | 4 ☐ Nursing | Home 5 Re | | | | |
| ding Phys | Certificate: | 1 Natural 2 Accident | 5 Pending | (Mont | th, Day, Year) | injury | work | yaı ⟨? Yes 2. □No | 28d. Describ | 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, | | | |
| Atten er dea' ector: by the | | 3 Suicide 4 Homicide | 6 Could no | ot be 28e. Place | of Injury - At I | home, farm, str | eet, factory, office | | | | | | |
| ital or irs afte al Dir | | | | 3 | ng, etc. (Spec | | | | 1 | fown, State | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans | Medical | (Check 2 | ■ Medical Ex | | is of examinat | ion and/or invest | tigation, in my opinio | on, death occurre | d at the time, dat | e and place | e, and due | e to the cau | se(s) and manner stated. |
| To the within Fo the somple | Σ | only one) 3 29b. Signature and t | | lurse Practitioner | O Mo | my knowledge | 29c. License | | place, and due | 1 | | Month, D | - |
| | | Uche | noly | Hos i | Pali | is C | 266 | 136 | | 2 | 117 | 112 | |
| | | 30. Name and addre | ess of person w | H | | em 23a) (Type, F | Print) | a la | 2 | 0.0 | Δ. | 4 | 0 |
| | | 31. Date filed (Month | 7. Day Year | | 700 (J e'gistrar's Sigr | PPEV - | Mesapa | 2011 (| Wive | bel | MY | Ma | 21014 |
| State Registra | | | EB 2 1 2 | 012 | we j | 8. pa | ples | | | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 00 25AM February 2012 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 0 lumbia Howard Vursing Home 0 lumbia Social Security Number Sex. If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day -11-204 **Director** Usual Residence of Deceden 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Howas 1 Yes 2 No 11 6571 10e. Street and Number 10g. Citizen of What Country? Funeral 87 U.S.A JOHNSL 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. ASION If Yes, Give Year or Dates Specify 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) AUTO MOTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LINK ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kaitlins KYRONG LRR 2209 Ellicon City, MD daughter CT. 21043 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Meadowridge Mem -2012 ElKridge, MI) Signature of Funeral Service Licensee towell Howelly Guiffor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Physician se disease or condition resulting in death) Medical Due to (or as consequence of): Examiner pheumon Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin weeks sician and burial-transit trac Hospital or Attending Physician; The law requires that the death certificate be executed Urinary that initiated events Due to (or as a consequence of) resulting in death) Last ng physician a as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the attending posterior to the IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Other (specify) n signed by the a Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an cate has t page 2 s autopsy After this certificate Yes 25. Was case referred to medical Be director 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1. Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For | State of I | Maryland | / Depa | artment of H | lealth a | and M | | | 012 | 04854 | |
|-------------------|--|----------------|--|--|--|---------------------|--|----------------|--------------|--|-----------------------------|--------------------------------------|---------------------------------|--|
| | | | = State Registrar | | | Cei | rtificate of I | Deam | | 2. Date of Deat | eg. No. | | 3. Time of Death | |
| | Physicia | | Decedent's Name (First, Middle | e, Last) | | | | | | Month | Day | Year 2012 | 12.45 PM | |
| 1 | /Medic | 21 | SHIRLEY la. Fecility Name (If not institution | A | |) M1 | 4b. City, Town, or | r Location o | of Death | 62 | 4c. Cou | nty of Death | | |
| | Examin | er ' | ~ | | | 71 | D A 1 | TIN | A in la | 212 | | | | |
| | | | 5. Social Security Number | G. Sex 7. | Age (In yrs. la | st birthday) | If Under 1 Year | If Under | | 8. Date of Birth | Voar | 9. Birth | nplace (State or Foreign | |
| H. | Funeral Director | | 218-60-4193 | 1□M 2 5 F | 58 | Yrs. | Months Days | Hours | Min. | 8. Date of Birth (Month, Dey 6/30/ | 53 | Was | hington DC | |
| | D. | | Usual Residence of Decedent | | 10a City | Town or Lo | conting | | | | | | 10d. Inside City Limits | |
| | show | | 10a. State 10b. County | _ | , | | | | | | | | 1⊠Yes 2□No | |
| | Ne M | Director | MD 10e. Street and Number | | | Balti | nore | | | 1 | 10g. Citizen | of What Co | untry? | |
| | with the or it | | | Street | | | | 223 | | | | USA | | |
| | heath me 23 | Funeral | 1811 S. Ramsey | 12. Was Decede | ent Ever in U.S | S. 13. | Was Decedent of H | | igin? (Spe | ecify Yes or No- | 14. | | rican Indian, | |
| (O | or Iter | Fun | 1 Never Married 2 Mar | rried Armed Force 1 Yes 2 If Yes, Give | | ļ | 1 ☐ Yes 2 ☑ No | | | mouri, oto-y | | ecify: | , 0.0. | |
| 215-0036 | ral', o | d by | 3 ☐ Widowed 4 🔀 Divorce | d Year or Date | es: | | | | | | | | hite | |
| 2 | 72 h | Completed | 15. Deceder (Specify only higher | nt's Education est grade completed) | | (Give | dent's Usual Occup kind of work done DO NOT use retire | during mos | t of worki | ng | 160. Kind (| or Business/ | moustry | |
| 7 | within ane. than | du | Elementary/Secondary (0-12) | College (1-4 | or 5+) | | Homemaker | | | | | Home | 2 | |
| N D | filed within 72 hours after death with the Maryland Hygiene. Ithar than "natural", or Iteme 23s or 28s-f show ent, Its Medical Evantine must be notified at | | 11. Father's Name (First, Middle | , Last) | | | Homemaker | | er's Name | (First, Middle, | Maiden Sui | | | |
| au | Mental Mental arked o | To Be | Marion Norwoo | od Bryant | | | | | Vi | ola Lou | ise M | ills_ | | |
| Maryland 21 | Sp E E | - | 19a. Informant's Name/Relation | ship (Type, Print) | | 19b. Mail | ing Address (Street | | | | | | Zip Code) | |
| | and 2 ealth a n 27 is | | Thomas K. Ludwi | ig Sr. / Som | | | von Ave. | Balt | | e, Mary | land | 21222 | Town, Stete | |
| ore | of He of He if item | | 20a. Method of Disposition 1 Burial 2 Cremation | 3 □Removal from St | ate ce | emetery, cre | osition (Name of ematory or other pla | 1 | | | | | | |
| E | Pa nen nen ant | | `4 □Donation 5 □ Other (| Specify) | Lou | | ark Cemet | | | | | | | |
| Baltimore, | permit. Pages 1 and Department of Health Importent: If item 27 any injury or othar tr once. | | 21. Signature of Funeral Service | 3 Licensee | 1 | | 8620 Wilke | | LC | oudon Pa | | | | |
| | 42244 | | 23a. Part 1. Enter the disease, o shock, or heart failure. Lis | or complications that can | used the death | . Do not er | nter the mode of dyi | ng, such as | cardiac | or respiratory ar | rest, | ı yıdır. | Approximate Interval Between | |
| | * | | Immediate Cause (Final | it only one cause on each | ch line. | | | | , | | | | Onset and Death | |
| 7 | Physician /Medical | | disease or condition resulting in death) | a. Due to (o | r as a consequ | ience of): | exa | cay | ba | tion | | | 100 | |
| | Examiner | | World Sale World and analysis and | h Pr | eum | one | · Ca | | | | | | lux | |
| Н | D = | ner | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or | as a consequ | nce of): | | | | | | | | |
| | and trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (o | r as a consequ | ence of): | | - | _ | | | | | |
| 760, | The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit | cal E | | 505 10 (0 | 1 43 4 00110040 | 30.100 017. | | | | | | | | |
| 687 | physicate s the | | | d | | | | | | | T.S. | | | |
| Box (| eath certificate attending phy I for use as the | N/M | IF FEMALE: 23b. Was decedent pregnant | □Ectopic pregnanc | 31/ | | | 230 | . Date of de | | | | | |
| B. | death e atte d for | icla | in the past 12 months? | 4☐ Pregna | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | | | | | | | | Month Day Year | |
| P.0 | at the de by the | Physiclan/Medi | 9 🗌 Unknown | | | | | in Dead | | 23e Did t | obacco use | contribute | o the cause of death? | |
| | es that igned b | by | Part II. Other significant condi | tions contributing to dea | ath but not rest | uiting in the | underlying cause g | iven in Pari | , I. | | Yes 2 🔯 | _ | robably 4 Unknown | |
| ord | w require been sig | eted | cold chasity leap Aprila 24a. Was an | | | | | | | | | 24b. Were autopsy findings available | | |
| Sec | e law has b je 2 si | Completed | | | | | 1 1 | | | auto | psy prmed? | prior to death? | completion of cause of | |
| alF | | | | | | | | ae Plac | on of Dea | 1 ☐ Yes | | 1 LI Ye | s 2 No | |
| of Vital Records, | ysician: Is certific director, | o Be | 25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No | Heorital: | patient 2 | ER/Outpati | ent 3 DOA | thor | | ome 5 Resi | | Other (Sp | ecify) | |
| of | g Phys er this eral di | n: To | 27. Manner of Death | 28a. Date of | | 28b. Time Injury | of 28c. Inju | ury at ork? | | 28d. Describe | how injury | occurred | | |
| ion | ath. r: Aft | atio | E C Frooidoire | stigation | , 22, 73, | | | Yes 2 | □No | | | | | |
| Division | rr Atte ter de irecto ir by th | Certification: | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide dete | mined 286. Flace | of Injury - At ho g, etc. (Specif | | street, factory, office | Э | | | (Street and I wn, State) | Number or i | Rural Route Number, | |
| | urs af | | 20 Cartina at Differentia | ying Physician: To the | hast of my kno | wladaa da | ath occurred at the | time date a | and place | and due to the | cause(s) a | nd manner a | as stated. | |
| | To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to | Medical | 29a. Certifier 1 Certification (Check only 2 Medic one) | el Examiner: On the ba and mann | sis of examina | ition and/or | investigation, in my | opinion, de | eath occu | rred at the time, | , date and p | lace, and di | ue to the cause(s) | |
| | Fo the within Fo the somple | Me | 29b. Signature and title of certi | fier | | | 29c. Lice | nse numbe | r | | 29d. Date | signed (Moi | nth, Dey, Year) | |
| | | | Dasi | ZM, D. | | | | D17. | 207 | 2 | 2/14 | +/12 | | |
| | | | 30. Name and address of person | on who completed cause | e of death (Iter | n 23a) (Typ | e Print) | | | | | - | | |
| | | | SATPAL DI 31. Date filed (Month, Day, Ye | TNG MID. | IOI ST | HEL ature | - Make | 4 B | ALT | MURI | EM | D, 2 | 1222 | |
| | St Regist | ate trar | FEI | B 2 1 2012 > | Ceneur | U A | - Marke | | | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

| | | | 1 = For State Registrar | State of Ma | | epartment of I Certificate of | | | giene Reg. No. | 2012 | 04855 | | |
|--|--|----------------|---|--|--|--|---|--|--|--|--|--|--|
| Physicia: /Medica | | | 1. Decedent's Name (First, Middle, Last) Daniel Joseph Lasser 2. Date of Death Manth February 11, 2012 | | | | | | | | | | |
| 1 | Examir | | 4a. Facility Name (If not institution, giv Shady Grove Advent | | g Center | | or Location of Death | | | County of Death | ry | | |
| | Funeral Director | | 377-34-4374 | Sex 7. Age | (In yrs. last birth | last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or F | | | | | lace (State or Foreign try) York | | |
| laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural"; or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at | show | _ | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | | | | | 10d. Inside City Limits | | | |
| h the M | r 28a-f notifie | Director | Maryland Montgor 10e. Street and Number | | Rockville 10f. Zip Code | <u> </u> | | 10g. Citiz | zen of What Coun | 1 X Yes 2 □ No try? | | | |
| eath wit | is 23a o must be | Funeral D | 9701 Medical Cer | nter Drive | vor in IIS | 12 Was Doordont of I | 20850 | | | ted State | | | |
| 036 ours after d | Department of real and mental rigitient. Department of real and of mental rigitient in the most series and show any injury or other traumatic event, the Medical Examiner must be notified at once. | وا | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | Armed Forces? 1 ⊠ Yes 2 □ N If Yes, Give Year or Dates: | 0 | | Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| Maryland 21215-0036 | e. an "natu Medical | Completed | 15. Decedent's Ed (Specify only highest grades) | ade completed) | (Give kind of work done during most of working life. DO NOT use retired) | | | | 16b. Kin | 16b. Kind of Business/Industry | | | |
| d 21 | ther the | Con | 17. Father's Name (First, Middle, Last, | 4 | Con | mputer Scie | ntist 18. Mother's Nam | e (First, Middle. | | ufacturi | .ng | | |
| ylan ould be | arked catic eve | To Be | David Lasser | | | | Florence | e Glass | berg | | | | |
| and 2 sh | n 27 Is m nertraum | | 19a. Informant's Name/Relationship (Laura V. Farthing | | 451 | Mailing Address (Street Hungerford | | | Roc | kville, | MD 20850 | | |
| Baltimore, | rtant: If ite | | 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 4 □ Donation 5 □ Other (Specif | (y) | Montgo | Disposition (Name of crematory or other planery or ium, Inc. | Febru 20 | | y 16, Bethesda, Maryland eral Home/Rockville, Inc,Rockville, Maryland 20850 | | | | |
| Bal permi | Impo any Ir | | 21. Signature of Fungal Serve Licer | | 0198 | Robert A. 1 300 West Mo | Pumphrey F ntgomery A | uneral F Ave.,Roc | lome/ kvil | Rockvil le,Maryl | le, Inc. and 20850 | | |
| | /sician | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) Failure to Thrive | | | | | | | | | | |
| | ledical aminer | | resulting in death) | | to (or as a consequence of): n - Melanoma Skin Cancer | | | | | | | | |
| nted | nsit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Dile to (or as a | nunsequence of |)· | | | | | | | |
| 68760, ificate be executed | g physician and is the burial-transit | edical Exa | that initiated events 'resulting in death) Last | C. Due to (or as a | consequence of | iequence of): | | | | | | | |
| Records, P.O. Box 68 The law requires that the death certific | by the attending ph stached for use as t | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown | Fetal death | 3 ☐Ectopic pregnanc 5 ☐ Other (specify) _ | her (specify) Month Day Year | | | | | | |
| dS, P | gned oe de | ρχ | Part II. Other significant conditions of Dementia | s contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒Unkno | | | | |
| Vital Records, sician: The law requires t | nas been si s 2 should b | Completed | Parkinson's Dise | ease | | | | 24a. Was an 24b. Were autopsy finding: | | | psy findings available | | |
| | certificate has l irector, page 2 s | | 25. Was case referred to medical | | | | 26. Place of Deat | perfor 1⊟ Yes | med? 2X No | death? | 2□ No | | |
| | this cer al direct | To Be | examiner? 1 ☐ Yes 2X No | | t 2 ER/Outp | attent 3[] DOA | her: 4 Nursing Ho | ome 5□Resid | ence 6 | i □Other (Specif | /) | | |
| VIVISION OF VITA or Attending Physician: | r: After | ation: | 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day | | ury Wo | ry at rk?]Yes 2 □No | 28d. Describe h | ow injury | occurred / | | | |
| DIVISION OF tal or Attending Physical arter death | al Directo | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | y - At home, farn (Specify) | n, street, factory, office | | 28f. Location (S City or Tow | (Street and Number or Rural Route Number, own, State) | | | | | |
| he Hospit | To the Funeral Direction of the Completely filled in the Complete of the Compl | Medical (| 29a. Certifier 1 (Check only one) 1 ■ Certifying Ph 2 ■ Medical Example | ysician: To the best of niner: On the basis of and manner stat | examination and | death occurred at the to for investigation, in my | ime, date and place, opinion, death occur | and due to the orred at the time, o | date and | and manner as si place, and due to | ated. the cause(s) | | |
| Tot | Tot | Σ | 29b. Signature and title of certifier | M | ρ. | 29c. Licens | se number 169800 | | | e signed (Month, uary 13, | - | | |
| 10 | X, En | | 30. Name and address of person who Tao Yu, M.D. 152 | | ath (Item 23a) (T | ype, Print) d #130, Ro | ckville, | | | 0850 | OMBOS | | |
| | Sta Registr | Ċ | - | 32 Registra | | | - | - | | | | | |
| DHMH 1 | 7 Rev 1/20 | | | 700 | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Robert Μ. Lambert Month 02 2012 5:42a.M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3024 Chelsea Ter. Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Min. 239-36-1439 1**X** M 2 □ F 09 08 25 NC 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore 1 🛚 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 3024 Chelsea Ter. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8th grade na Bricklaver Various Jobs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Lambert Sr. Bertha Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose O. Lambert-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Memorial 2/18/2012 Arbutus Arbutus, Signature of Juneral Service L 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, ma Baltimore, Md then the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Candlo vascular disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Ph_sician/ Medical **Examiner**

> and burial-tran

physician

the use as

be detached the

should

page 2 s

Be

6

Certificate:

Medical

filled in by the funeral director,

completely

certificate

this

hours after death. neral Director: After

within 24 hours a To the Funeral D Hospital

à

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

ed other than "natural", or items 23a or event, the Medical Examiner must be

and Mental Hygiene.

permit. Page 1 and 2 should be the Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.

Maryland 21215-0036

Baltimore,

ò

Director

Funeral

þ

Completed

Be

ပ

Examine Physician/Medical Completed by

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

25. Was case referred to medica

1 Yes

27. Mannet of Death

1 Matural

Accident

Suicide

4 Homicide

29a. Certifier

(Check

only one

2 No

5 Pending

Investigation Could not be

determined

24a. Was an

24b. Were autopsy findings available prior to completion of cause of

autopsy perform death? 1 Yes 2 No 1 🗌 Yes 2 🐼 No 26. Place of Death (Check only one)

| 4 | Nursing | Home | 5 Residence | 6 ☐ Other (Specify |
|---|---------|------|------------------|--------------------|
| t | | 28d. | Describe how inj | ury occurred |
| s | 2 🗌 No | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number.

| th occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
|--|--|
| on, in my opinion, death occurred at the time, date and place, and due to the cause(s) a | |
| rred at the time, date and place, and due to the cause(s) and manner as stated. | |

H0064780

Other:

work? 1 ☐ Yes 2 ☐ N

28c. Injury at

29d. Date signed (Month, Day, Year) 2012

me and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

Linder Are Belhnore 827 tal Maylone 31. Date filed (Month, Day, Year) 32. Registrar's Signatu

28a. Date of injury (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occu Medical Examiner: On the basis of examination and/or investigati

Certifying Nurse Practitioner: To the best of my knowledge, dea

State Registrar

DHMH 17 Rev 06-2011

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year William August Leimbach, Sr. 415 2012 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLin Square Hospital ROS LTIMOR 6. Sex 1 M 2 F If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Month 105/1918 Maryland 212-07-7549 93 Director 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No MD Baltimore Essex 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 1900 Grove Manor Drive 21221 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Â\(\sigma\) 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner 2 No Air Force Black, White, etc. þ 1 Never Married 2 X Married ō nours after If Yes, Give Year or Dates. 1942-45 1 ☐ Yes 2 X No Specify. "natural". 3 Widowed 4 Divorced Specify Completed White the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. 3altimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Typesetter 12 Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည pe other traumatic August Leimbach Anna Mowbry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Ann Leimbach / Wife 1900 Grove Manor Drive, Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 No Cremation 3 ☐ Removal from State ō Department of Important: If any injury or Chesapeake Crematory 2/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Due to (or is a consequence of) disease or condition Medical resulting in death) Examiner or as a consequence of): Sequentially list conditions, if any least state underlying cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Live Birth Z L Fetal Salar Pregnant at time of death Month Year g Unknown g 🔲 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? Director: After this certificate 2 No 1 Yes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work Accident
Suicide 1 Yes Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2-20-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21237 FRANKLIN Square DR Balto 9000 ind Nelia E.

State Registrar 32. Regis rar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Delores Lawrence 10 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchie House Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 D M 2 D F Months Days (Month Day 1936) Country) Nkn. 213-34-8612 75 **Director** items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4610 Eugene Ave. 21206 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 9 by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Completed 3X Widowed 4 ☐ Divorced White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 72. h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12 Nurse's Aid Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unkn. Unkn. Jet 1 and 2 shc Jepartment of Health and Important: If item 27 is many injury or other 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalind Jones / POA 2000 Mars Run Road, Baltimore, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/20/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and I-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day 1 ☐ Yes ∠ y 9 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 XN0 မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Hofolie) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical

Division of Vital Records, Lawrelle

2/12/12

DHMH 17 Rev 06-2011

Registrar

29a. Certifier

(Check

Date filed (Month,

29b. Signature and title of certifie

FEB 2 1 2012

B) 1

Gertifying Nurse Frantitioner To the best of my lenowledge

Cevant Boun

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

curved at the time; data and place; and due to the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year 20, 7:45 PMM 2012 February McCoy, Denney Α. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Middle River Ivy Hall Geriatric Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/16/1937 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days 1**X** M 2 □ F Vĭrqinia 74 223-44-0369 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Middle River Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt 1A 21220 U. S. A. 201 Midlass Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Xes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1888 Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Millwright 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown McCoy (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 201 Midlass Drive Apt 1A Middle River, Maryland (Son) Mark Meyers 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 2/25/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only she cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Discord Obstruction Chronice disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 2 **N**o 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

after

72 }

12 should be filed w hand Mental Hygier 7 is marked other th

permit. Pages 1 and 2.
Department of Health at Important: If item 27 is any injury or other trau.

3altimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

death certificate be

Director

Funeral

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Completed

Be

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Examiner

burial-transit Physician/Medical ð Completed Be ၉

physician the as ţō signed by the a page certificate funeral director, After this Certification: al or Attendi s after death. al Director: A death. filled in by within 24 hours at To the Funeral D

State Registrar

Medical

29b. Signature and title of certifier 20Man

6 Could not be determined

MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D 31464

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MD 821 N. ENTAN ST Ante 308 Baltonne MD 21261 IMMIZAH SHOALB A

31. Date filed (Month, Day, Year)

2 Accident

4 ☐ Homicide

(Check only

3 ☐ Suicide

29a. Certifier



DHMH 17 Rev 1/2001

| 2-01442 | | Please Typ | oe or Print i | n Black Ind | elible In | ık. Ensui | re All C | opies Are Le | gible. | | |
|--|----------------|---|---|--|--------------------|--|-----------------------------|---|-----------------------------|---------------|--|
| argaret Teresa Monius State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Per No. 2 1 2 | | | | | | | | | |) 0100 | |
| Physici | | Registrar 1. Decedent's Name (First, Middle,Last) | | | | | | | eg. N o. | J 1 2 | 3. Time of Death |
| ledical Exami | -11/ | Margaret Te | | onius | | | | Month February | | | 1522 hrs |
| | | 4a. Facility Name (if not institution 783 White Oak Drive | of Death | 4c. County of Harford | of Death | | | | | | |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. | | | | | | | rth (MM/DD/YYYY | 9. Birthp | place (State or |
| Director | | 219-06-2883 | 1 M 2 X F | 28 | Yrs. | Months Day | ys Hours | | 11, 1983 | | ÿland |
| any | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, To | own or Location | on | | | | 1 | 10d. Inside City Limits |
| | Ž | Maryland Harfo | rd | Pyl | esvill | e | | | | | 1 Yes 2 X No |
| r with the Maryland ms 23a or 28a-f show be notified at once. | Director | 10e. Street and Number | | | | 10f. Zip Code | | 1 | 0g. Citizen of Wh | at Country | у? |
| th the 23s or notific | | 631 Saint Mar | | added From to 11 C | 12 14/00 | 21132 | | | United S | | S an Indian, Black, |
| eath wi | uneral | 11. Marital Status 1 X Never Married 2 M | arried Armed F | cedent Ever in U.S. orces? | | | | gin? (Specify Yes or No , Puerto Rican, etc.) | White | | in indian, black, |
| after de | by F. | 3 Widowed 4 Div | orced If Yes, Give Yes or Dates: | | 1 | Yes 2 🔀 No | specify: | | Specify: | White | e |
| hours. | ted t | Decedent's Education (Spe Elementary/Secondary (0-12) | cify only highest gra | , , | | 's Usual Occupa est of working life | | kind of work done use retired) | 16b. Kind of Bu | siness/Ind | lustry |
| 36 thin 72 se. than ' | Completed | 12 | 2 | | Ađmini | .strativ | re Ass | istant | AAI Co | rnor: | ation |
| 5-0(lled wi Hygier I other | | 17. Father's Name (First, Middle, | | | _ | | | 's Name (First, Middle, | | | 21.11.71) |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica | o Be | John G. Moniu 19a. Informant's Name/Relations | | | 19h Mailing | Address (Stre | | hia D. Eake | | n State 7 | Zip Code) |
| MD 2 12 shou th and N 1 27 is n | 1 | John G. Monius | | | | (| | ad Pylesv | | | |
| re, I and F Healt | Ш | 20a. Method of Disposition 1 X Burial 2 Cremation | 2 Pemoval f | 20b. Pla | ce of Disposit | tion (Name of ce | emetery, | Feb. 23, | 20c. Location - | City or To | own, State |
| Baltimore, permit. Pages 1 ar Department of Hee Important: If ite | | 4 Donation 5 Other Sa | pecify: | | | Cemeter | | 2012 | | | , Maryland |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Funeral Service | -1/0 | | Eva | ame and Addres NS Fune | ral C | hapel & Cre | emation : | Servi | ice-BelAir |
| Physician | | 23a. Part I. Enter the dilease, or failure. List only one cause | complications that o | aused the death. De | o not enter th | e more of dying | Drive such as c | ar liac of respiratory in | ost, shock here | and | Approximate Interval Between Onset and |
| /Medical Examiner | | Immediate Cause (Final disease | _{a.} Hanging | | | | | | | | Death |
| 1 | | or condition resulting in death) | Due to (or as a | a consequence of): | | | | | | | |
| | miner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | Due to (or as | a consequence of): | | | | | | | |
| i i | Exam | (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a | a consequence of): | | | | | | | |
| executed an and al - transit | | | d | | | | | | | \rightarrow | |
| ox 68760, eath certificate be exe attending physician a for use as the burial - | cian/Medica | UNPENDED IF FEMALE: | AMENDED | outcome of pregnar | acv. | | | | 23d. Date of | delivery | |
| 6876 ertifica ding ph | an/N | 23b. Was decedent pregnant in the past 12 months? | ne 1 Live I | oirth | 2 Feta | al death 3 | Ectopic | pregnancy | Month | Day | y Year |
| Box 68760, : death certificate be the attending physic df for use as the bur | Physici | 1 Yes 2 No 9 V Uni | | nant at time of death own | ¹ 5 Oth | er (Specify) | | | | | |
| P.O. Best that the degreed by the | | Part II. Other significant condit | ions contributing t | o death but not resu | ılting in the ur | nderlying cause | given in Pa | | | _ | e cause of death? |
| S, P uires th n signe Id be d | ed by | | | | | | | 1 Ye | s 2 No 3 | | bly 4 Unknown |
| cord law req has bee 2 shou | Completed | | | | | | | autop | osy p | | mpletion of cause of |
| of Vital Records, ng Physician: The law require the this certificate has been si meral director, page 2 should b | | 25. Was case referred to medica | | | | 26 Place | o of Dooth | | | Yes | 2 No |
| /ital ysician nis cert | o Be | examiner? 1 Yes 2 No | I I a a mid a li | Inpatient 2 E | R/Outpatient | | Tou | Nursing Home 5 | Residence 6 | Other: S | Scene |
| 1 of Vital Records, P.C. Ling Physician: The law requires that. After this certificate has been signed funeral director, page 2 should be det | \vdash | 27. Manner of Death | 28a. Date | Day Year) | 8b. Time of In | ` | ury at Work | Subject har | how injury occurrenced self | ed | |
| Division tal or Attendi rs after death. | catio | | stigation Feb 18, | | 515 hrs | | Yes 2 ✓ | No , | | ar or Pura | al Route Number, City |
| Divi | Certification: | | a not be | Townhouse / | | | building, et | or Town, S 783 White Oa | State) ak Drive , Bel A | ir, MD | Trodic Hamber, Ony |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn | Medical Co | 29a. Certifier | hysician: To the be miner:On the basis | st of my knowledge, of examination and/ | death occurr | ed at the time, o | late and pla n, death oc | ace, and due to the cause curred at the time, date | se(s) and manner | as stated | cause(s) |
| To with | Mec | 29b. Signature and title of certifie | and manner s | stated | | 29c. Licen | | | 29d. Date signe | | |
| | | + M. | It | | | 0.0 | .M.E. | | February 1 | 9, 2012 | |
| _ | | 30. Name and ddress of person Jack Titus MD. Dep | 70017 | | | altimore Str | eet Ralt | imore, MD 21223 | | | |
| | | Jack Hus ND. Det | one med | Cur Examino | 500 TT. D | C.(510 Otl | , Duit | | | | |

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene _ State Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 15 February Physician/ 07:45 P^M 2012 Mihaley Olga Μ. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Severna Park Genisis Elder Care 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours ountry) 129-26-7345 Oct 1,1919 PA 1 🗌 M 2 🔀 F **Director** 92 10d. Inside City Limits 10c. City, Town or Location Chester 28a-f show 10a. State 10b. County notified at Director Oueen Anne Maryland 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21619 the Medical Examiner must be 107 Kirwans Landing Lane USA by Funeral 23a items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 X No Yes, Give ō white 1 ☐ Yes 2 ▼ No Specify: Baltimore, Maryland 21215-0036 "natural", 3 XWidowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) pharmaceutical supervisor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stalbovsky and Mental h Maria 2 Halesky of Health and Menta Anthony t: If item 27 is marke or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State Zip Code) 107 Kirwan's Landing Lane Chester MD 21619 19a. Informant's Name/Relationship (Type, Print) daughter Marie A Baehr 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition St Cyril Methodrius Cem 2/23/2012 Windber PA 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stallings Funeral Home P.A. 21. Signatur 3111 Mountain Road Pasadena MD 21122 not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physician ansthe burial-tr resulting in death) Last Be Completed by Physician/Medical Box 68760 or Attending Physician: The law requires that the death certificate 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Year in the past 12 months?

1 Yes 2 D No 1 Yes 2 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. peint disease 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division M Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitional Type Seed of my broad of death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurse Practitioner: T P0062395 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

ADMIRAL DVIVE ANNAPOLIS MD 2140/.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month :09 AM Edgar Lee Mercer, Sr. February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Dove House 5. Social Security Numbe 6. Sex 1XXM 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, OV. 17 Days Hours Min. Months 86 **Director** 220-20-0730 1925 Nov. Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2XX No Baltimore Hampstead MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States ò Funeral "natural", or items 23a 17220 Grace Road 21074 America permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed Year or Dates White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Baltimore Co. Gov't Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nettie Louise Hefner Harry Roger Mercer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17220 Grace Rd., Hampstead, MD 21074 Harriet E. Mercer (Wife) Injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State All Faiths Crematory or other place) & Chapel 2/21/2012 | Manchester, Maryland 4 Donation 5 Other (Specify) of Funer Service Livers 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr., Manchester, MD 21102 ard 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hack, or heart failure. List only one cause on each line. shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Interval Betweer Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of physician and s the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Other (specify) Month Pregnant at time of death Dav Year ☐ Yes ∠ ☐ Unknown been signed by the should be detached 9 Unknown Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 🗌 Probably 4 🗀 Unknown 1 Yes certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No HODICE မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 5 Pending 2 🗌 No n 24 hours after death.

le Funeral Director. A pleted filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, Homicide determined City or Town, State Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho
To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Dav. Year) N5059942 12012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day May 307 wesminster ann(

DHMH 17 Rev 7/2009

State Registrar 31. Date filled (Month, Day, Year)

| | | 1 | AMEND #25 | Please PER ME | Type or Pr G928 6/28 State of N | int in 112 T Tarylan | Black Ir RT d 7 Depa | n <mark>delible l</mark> a artment of | n k. En Health | sure Al | I Copie ental Hy | s Are | e Legible | | |
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| | | | State Registrar | | | | | tificate of | | | | Reg. No | 0011 | | 1863 |
| | Physicia Medic | | 1. Decedent's Name | e (First, Middle, Las IER | MI | LES | 5 | | | | 2. Date of De | eath Da | ay 201 | 3. Tim 2 3 | e of Death |
| | Examir Funeral | er | 4a. Facility Name (if UTUR) 5. Social Security N | | SANDTO | DWN | 1000) ast birthday) | 4b. City, Town, V GILI If Under 1 Year | MOR | E 51 er 24 Hrs. | REE / | $\frac{7B}{\text{th}}$ | | MORE | 2/2/ te or Foreign |
| | Director | | 213-32- Usual Residence of | 9216 Decedent | □ M 2 □ F | 82 | Yrs. | Months Day | 's Hours | Min. | 07-04 | ay, Year) -29 | Co | MI | |
| | aryland a-f sho fied at | Director | 10a. State | 10b. County NA | | | y, Town or Lo ltimo | | | | | | | | e City Limits |
| | the Mi or 28 se noti | I Dire | MD 10e. Street and Nur | | | | | 10f. Zip Code | 9 | | | 10g. Ci | itizen of What C | ountry? | |
| | h with ns 23a nust k | Funeral | 100 Gi | lmor Str | | | | | 217 | | | | USA | , | |
| 920 | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by | 11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed | ied 2 🗆 Married 4 🌂 Divorced | 12. Was Deceden Armed Forces 1 X Yes 2 I If Yes, Give Year or Dates. | ? | | Was Decedent of f Yes, specify Cu I ☐ Yes 2 🛣 | | | ify Yes or No- ican, etc.) | | 14. Race - Ame Black, Whit Specify: Am | e etc | rican |
| 5-0 | 2 hour "natu | plete | (Spe | 15. Decedent's Ed | | | (Give | dent's Usual Occ kind of work don | e durina mo | ost of working | a | 16b. k | Kind of Business | | |
| 21215-0036 | ithin 7 ene. r than the Me | Completed | Elementary/Sec 12th G | * ' / | College (1-4 or | 5+) | life, D | O NOT use retire Chef | d) | | | | anneri | | |
| d 2 | 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M | Be | 17. Father's Name (| | NA. | | | | 18. Mo | ther's Name | (First, Middle | | staura Surname) | <u> </u> | |
| ylar | Menta | 2 | Sydn | | Miles | , Sr | _ | | | nnie | | | Tongu | | |
| , Maryland | and 2 shou Health and :em 27 is rr ither traum | | Brian | me/Relationship (Ty Miles-S | | | 1008 | ng Address (Stree South | | | | | | | 21228 |
| Baltimore, | a 0 + - | | 20a. Method of Disp | position $lacktriangle$ Cremation 3 \Box 5 \Box Other (Specify | Removal from State | te c | emetery, crer | sition (Name of natory or other p | | | ate | | ocation - City o | | |
| altir | permit. Page Department Important: I any injury o | | | neral Service Licens | | ме | | remato . Name and Add | | | 1-12 ie Fu | | tonsvi al Hom | | |
| ñ | a E G | | | ////// | reflee | | 6 | 38 N. | Gilm | or St | reet | Bal | | | |
| ر معموری | Ph, i i n Medical Examîner | | 23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition resulting in death) | | a. Due to (or a | der | - Car | 7 CEV | ying, such a | as cardiac or | respiratory a | rrest, | | | Between and Death |
| | | iner | Sequentially list co if any, leading to in cause. Enter Unde | nditions, imediate dving | b. Eue to (or a | s a consequ | uence on. | | | 1 | | . ms/ 8. | MINER | | |
| 90 | te be executed nysician and he burial-transit | dical Examiner | Cause (Disease or that initiated event resulting in death) | iinjury s | c. Due to (or a | s a consequ | uence of): | | CERTIFIC | CATION APPR | OVED BY MED | ICAL EXA | Witter | | |
| . Box 68760 | Attending Physician: The law requires that the death certificate be ar death. ector: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the but | Physician/Medical | IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown | nonths? | 23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknowr | 2 Feta at time of o | al death 3 | Ectopic pregna Other (specify) | | | | | 23d. Date of de Month | elivery Day | Year |
| ls, P.O. | v requires that to been signed be should be deta | | | cant conditions co | | | | | | | | | use contribute to | | |
| Division of Vital Records, | ician: The law req certificate has bee rector, page 2 sho | Completed by | demer | itia, c | ache | xia | , 50 | acral | WOU | nd | 24a. Was auto perfi 1 \(\sum \) Yes | | death? | completion | |
| ita | sician: certific irector, | Be | 25. Was case referre examiner? 1 XYes 8 | | Hospital: | | | To | than a | eath (Check | | | | | F |
| on of V | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director, | cate: To | 27. Manner of Deatl | 5 Pending Investigation | 28a. Date of in (Month, D | jury | ER/Outpatier 28b. Time of injury | 28c. Inj | | _ 28 | ne 5 ∐ Resi 8d. Describe | | Other (Spec | cify) | |
| Divisio | ial or Atters a after deg | l Certificate: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not be determined | 28e. Place of Ir | njury - At ho tc. (Specify | | eet, factory, offic | e | 2 | 8f. Location (City or To | | d Number or Ru | ıral Route N | umber, |
| | the Hospithin 24 hour the Funerange ille | Medical | (Check 2 only one) 3 | Certifying Phys Medical Examin Certifying Nurs | ner: On the basis of | examination | n and/or inves | tigation, in my op death occurred at | inion, death the time, da | occurred at t ate and place | he time, date | and place ne cause(| e, and due to the s) and manner as | cause(s) and stated. | |
| _ | With Co | | 29b. Signature and | title of certifier | ny | 19 | Cu | 29c, Lice | nse number | 419 | 55 | | te signed (Mont | | |
| $\langle \cdot \rangle$ | | 1 | 50. Name and address | ess of person who c | ompleted cause of | death (Item | 23a) (Type, 7 | Print) Litchia | Hig | hwa | y#210 | o h | 2-20 Disade | ra A | 21122 |
| | Sta Registr | | 31. Date filed (Mont | EB 2 1 20 | 12 32. egis | trar's Signat | 8. A. | ald | | | | | | | - |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Z 15 2012 Physician/ MANNING FEBRUARY 8:55 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Birthplace (State or Foreign Country) If Under 1 Year If Unde 8. Date of Birth (Month, Day, Year) **Funeral** Months 216-32-3667 1 🗆 M 2 💢 F **Director** MD 10-08-28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director MD BAUTIMORE 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral HAMLET AVENUE 21214 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🏲 No If Yes, Give Completed by Baltimore, Marylǎnd 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 □ Divorced Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) DOMESTIC HOUSE KEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BUCKNER RACHEL BEALE WILLIAM 19a. Informant's Name/Relationship (Type, Print) (PTR) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1012 REVERDY ROAD. BANTO, MD. 21212 BUCKNER-MARINE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State BATIMORE, MD 2/22/12 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility VAUGHN GREENE FUNELAL SCYS M ORK ROAD. BALTO Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 g Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal insufficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury w<u>ork</u>? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number Cyuttia Small B 20051347 2/16/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CYNTUR SON and So 6701 Nicharles ST Basturiore Med 21204 Date filed (Month, Day, Year) 2. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ MAE MELVIN Month 11:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MANOR BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 246-24-9860 **Director** 1 □ M 2 🔀 F 11-16-1919 28a-f show items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral LOCH RAVEN 4600 21239 USA Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or ite 1 Never Married 2 Married Completed by 1 ☐ Yes 2 💆 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BURNETT COMPANY WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EASTER WILLIE NANNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAVEN BLVD. BALTO, MD, 21239 SON IN LAW 4600 LOCH 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State BALTIMORE, MD ARBUTUS CEMETERY 2/24/12 4 Donation 5 Other (Specify) 21. Signature Licensee 22. Name and Address of Facility VAUGHN EREENE FUNCTION SCVS YORK ROAD. BALTO, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown Linknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 № No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 🗹 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 40054424 2-16-12

7 11

DHMH 17 Rev 06-2011

Registrar

Luturally, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1012

tsade,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | for State Registrar | State of Maryland | | artment of H tificate of D | | | ene 20 | 12 04866 |
|---|-------------------------------|---|---|----------------------|--|--|---|---------------------------------------|---|
| Physicia | | 1. Decedent's Name (First, Middle, La Ruth Clarke Ma | st) rtin | | | | 2. Date of Death | | Qrl 2 37 mg & Reath |
| Medic Examin | | 4a. Facility Name (if not institution, giv 6825 Campfield R | e street and number) d. Apt 11-G1 | | 4b. City, Town, or Balti | Location of Death more | | 4c. County of Balt | Death Imore |
| Funeral Director | | | Sex 7. Age (In yrs. las | st birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth 1 16/19 2 | 2°) E | 9. Birthplace (State or Foreign Bartimore, Md. |
| Maryland 28a-f show otified at | rector | Usual Residence of Decedent Maryland 10b. County | | Town or Local | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| s vith the | ieral Di | 10e. Street and Number 6825 Campfield R | oad, Apt. 11-G1 | | 10f. Zip Code 212 | 07 | | g. Citizen of Wh | |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Thous marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Completed by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. | " | Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🛣 No | n, Mexican, Puerto I | cify Yes or No- Rican, etc.) | | American Indian, White, etc. White |
| within 72 ho giene. er than "nat the Medica | | 15. Decedent's I (Specify only highest gi Elementary/Seconday (0-12) | | (Give k life. DC | ent's Usual Occupa kind of work done du D NOT use retired) I'SE | ition uring most of workii | ng 10 | 8b. Kind of Busi Hea | iness Industry |
| d be filed valued Hygurked other | To Be | 17. Father's Name (First, Middle, Last) George Clarke | | - | | 18. Mother's Name | (First, Middle, Ma la Ohrma | iden Surname) nn | |
| d 2 shoulk alth and N 1 27 is ma er trauma | | 19a. Informant's Name/Relationship (George H. Martin | Jr./Husband | 196825 | g Address Street 1 | d Road, Ap | Boute Number C | ity BAYL Ita | ore, Maryland 20 |
| . Page 1 an tment of He tant: If item jury or othe | | 20a. Method of Disposition 1 🏻 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec | Removal from State | d Rid | sition (Name of natory or other place ge Cemete | ry Feb. 2 | 21,2012 | Pikesvi | ity or Town, State |
| permit Depart Import any inj | | 0000 | ters | _ 10 | Name and Address W. Pado | nia Road, | Timonium | ,Maryla | nd 21093 |
| Physician/ Medical Examiner | | 23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) | one cause on each line. | clery | r the mode of dying Disease | , such as cardiac o | r respiratory arrest | , | Approximate Interval Between Onset and Death |
| sate be executed physician and the burial-transit | edical Examiner | Sequentially list conditions, if any, leading to mineurate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last | c. Due to (or as a conseque | | | | | | |
| to the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 23c. If yes, outcome of pregnan 1 | death 3 | Ectopic pregnancy Other (specify) | / | | 23d. Date Monti | |
| luires tnat tr en signed by uld be deta | by | Part II. Other significant conditions of | contributing to death but not resu | iting in the u | nderlying cause give | en in Part I. | | | ute to the cause of death? |
| : The law rec cate has bee ; page 2 sho | Completed | | | | | | 24a. Was an autopsy performe 1 □ Yes 2 | pried? dea | re autopsy findings available or to completion of cause of ath? Yes 2 No |
| hysician his certifi Il director | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 ☐ Inpatient 2 ☐ E | | Other | ce of Death (Check r: 4 Nursing Hor | only one) me 5 🖎 Residend | ce 6 🗆 Other | (Specify) |
| ttending P death. tor: After t the funera | Certificate: | 27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be | (Month, Day, Year) | 28b. Time of injury | | ∕es 2 □ No | 28d. Describe how | | |
| pital or A ours after eral Direc filled in by | | 4 Homicide determined | building, etc. (Specify) | | | | City or Town, S | State) | or Rural Route Number, |
| the Hos ithin 24 ho the Fun | Medical | (Check 2 Medical Exam | sician: To the best of my knowle iner: On the basis of examination se Practioner: To the best of my | and/or investi | gation, in my opinior | n, death occurred at time, date and place | the time, date and pe, and due to the ca | place, and due to suse(s) and mann | o the cause(s) and manner stated. her as stated. |
| F ≥ F 8 | | I blyed dle | has MD | 220) (5: 5 | 072 | 139 | Fe | bruary | Month, Day, Year) 17th 2012 204. |
| 12 | | 30. Name and address of person who SYED ABBAS 6 31. Date filed (Month, Day, Year) FEB 2 | 701 N Charles | St. S | uli 4105 | Balt | more 1 | ND 27 | 204. |
| Stat Registra | e ar | FEB 2 | 1 2012 Agreement | A. | barker | | | | |

State Registrar DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Feb Year 1artinez 1405 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University of Maryland Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 217-51-0620 **Director** 1 🛛 M 2 🗆 F 08/18/1979 Guatemala Usual Residence of Decedent 28a-f show 10b. County ms 23a or 28a-f shor must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6925 Lachlan Circle 21239 Apt. A 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö by 1 Never Married 2 X Married Yes 2 X No 1 XX Yes 2 □ No Specify: Guatemalan 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural", Completed 3 Divorced Hispanic the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Dental Technician Dental Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martinez Sandra Michelena Edgar uge 1 and 2 si uepartment of Heath an Important: If item 27 is n. any injury or other * 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar R. Martinez, Father 6925 Lachlan Circle Apt. A. Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Hilltop Svc. Corporation : 02/27/2012 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. lletanduas Holain 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Becker's disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 2 🗌 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital 2 🗹 No Other: 1 Yes မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manny of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural (Month, Day, Year) Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Funeral Director: completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ad

DHMH 17 Rev 06-2011

4616

AU4176435H

Windsor

Bethesda

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | For State Registrar | C | ertificate of | | , , | Reg. No 2 0 | 2 04868 |
|--------------------------------|--|-------------------|--|---|--|---|---------------------------------------|----------------------------------|--|
| | Physici | an | Decedent's Name (First, Middle, Last) | | | | 2. Date of Dea | | 3. Time of Death |
| 4.4 | /Medic | | | gan, Sr. | | | 2 | 20 20 | 012 7:05 /4M |
| | Examin | er | 4a. Facility Name (If not institution, give street and number |) | | or Location of Dear | | 4c. County of | |
| | Funeral | - | 1204 Sedge Court 5. Social Security Number 6. Sex 7. Ac | ge (In yrs. last birthda | | adena If Under 24 Hrs | | Anne A | Arunde1 Birthplace (State or Foreign Country) |
| i. | Director | | 217-46-4532 1≅M 2□F | 65 Yrs. | Months Days | Hours Min | Feb. 22 | | Maryland |
| | land Dw | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or | Location | | | | 10d. Inside City Limits |
| | Mary a-f she | tor | Maryland Anne Arundel | Pasadena | | | | | 1 □Yes 2 No |
| | or 28g | Director | 10e. Street and Number | _ rasadena | 10f. Zip Code | | 1. | 10g. Citizen of Wha | it Country? |
| | ath wi | ral | 1204 Sedge Court | | 2112 | | | | U.S.A. |
| 10 | ter de | Funeral | 11. Marital Status 12. Was Decedent Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 Married | Ever in U.S. 13 | Was Decedent of If Yes, specify Cub | Hispanic Origin? (S pan, Mexican, Puer | Specify Yes or No- to Rican, etc.) | 14. Race - Black, \ | American Indian, White, etc. |
| 036 | 72 hours after death with the Maryland instural", or items 23a or 28a-f show dical Examinar must be redified at | by | 3 ☐ Widowed 4 ☐ Divorced | | 1 □Yes 2 🗷 No | Specify: | | Specify: \(\sqrt{1} \) | √hite |
| 5-0 | 72 hc "natu | Completed | 15. Decedent's Education (Specify only highest grade completed) | 16a. Der | cedent's Usual Occu ve kind of work done . DO NOT use retire | pation during most of wo | rking | 16b. Kind of Busin | ess/Industry |
| 12 | within iene. than | duic | Elementary/Secondary (0-12) College (1-4or N / A | 5+) | . DO NOT use retire stimator | ed) | | Constant | ation Company |
| פַ | al Hyg other vent, | Be C | 17. Father's Name (First, Middle, Last) | <u>1</u> | Stillatui | 18. Mother's Na | ne (First, Middle, | Maiden Surname) | ction Company |
| ylar | Menta Menta arked atic ev | 70 E | Norman Elmer Milli | gan | | Mabe1 | Alice | Seede | ers |
| Mar | 12 sho th and 7 is m traum | | 19a. Informant's Name/Relationship (Type. Print) | | iling Address (Stree | | | | |
| <u>ق</u> | 1 and Healt tem 2 | | Diana L. Milligan (Wife) 20a. Method of Disposition | | Sedge Co position (Name of rematory or other pla | | · · · · · · · · · · · · · · · · · · · | yland 21. 20c. Location - Cit | |
| Ē | Pages nent of nt; If i | | 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 1 | ematory`or other pla Crematio | | 1 | | nie, Maryland |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Externment or content traumatic event, the Madical Externment or content traumatic event, the Madical Externment or content traumatic event, the Madical Externment or content traumatic event, the Madical Externment or content traumatic event, the Madical Externment or content traumatic event, the Madical Externment or content traumatic event. | | 21. Signature of Funeral Service Licensee MOO-7 | | | | | lomo D A | iic, narytana |
| | # Q E # 9 | | the the | | 22. Name and Addr McCully-P 3204 Moun | | | | nd 21122 |
| | | | 23a. P. n.1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each limmediate Cause (Final | ine. | | | | rest, | Approximate Interval Between Onset and Death |
| | Physicían /Medical | | disease or condition resulting in death) | a consequence of): | 10 00 | ncer | | | luear |
| | Examiner | | | a consequence ory. | | | | | |
| | ed sit | iner | | a consequence of): | | | | | |
| P | sxecuti and al-trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last C | a consequence of): | | | | | |
| 68760,0 | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | | d | , , | | | | | |
| 89 | ertifica ing ph as th | Medical | IF FEMALE: | | | | - | | |
| Вох | eath cer attendir for use | Physician/ | 23b. Was decedent pregnant in the past 12 months? | 2 Fetal death 3 | Ectopic pregnan | су | | 23d. Date o Month | |
| o | at the de by the tached | ysic | 1 | it time of death 5 | ☐ Other (specify) _ | | | | |
| ď. | iires that signed b | by Pr | Part II. Other significant conditions contributing to death b | out not resulting in the | underlying cause gi | ven in Part I. | 23e. Did to | bacco use contribu | te to the cause of death? |
| Records, | w require been signations been signatured been signatured by | ted t | | | | | 1 🗆 Y | es 2.⊒1√No 3[| ☐ Probably 4 ☐ Unknown |
| Ş | e law r has be | Completed | | - | | | 24a. Was a | sy prio | re autopsy findings available r to completion of cause of |
| a | sician: The law certificate has l rector, page 2 s | | | | | | perform 1 □ Yes | med? dea 2 ☑ No 1 ☐ | th? Yes 2 □ No |
| Vital | Physician: r this certifica ral director, p | Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati | ent 2 ☐ ER/Outpati | ont all Dod Oth | or: | ath (Check only or | | |
| ם ר | ding Phy h. After this funeral d | ü | 27. Manne Death 28a. Date of Inju | ury 28b. Time | of 28c. Inju | ry at | | ence 6 Other (| Specify) |
| SIO | Attending Physician: r death. ector: After this certific. by the funeral director, t | catio | 2 Accident investigation | y, rear) injury | | Yes 2 □ No | | | |
| Division of | after date date de Direct | Certification: To | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inj building, et | ury - At home, farm, s c. <i>(Specify)</i> | treet, factory, office | | 28f. Location (S: City or Town | treet and Number o n, State) | or Rural Route Number, |
| | spital | | 29a. Certifier 1 Certifying Physician: To the best | of my knowledge, de | ath occurred at the t | ime, date and plac | e, and due to the o | cause(s) and mann | er as stated. |
| | To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b | Medical | (Check only one) 2 Medical Examiner: On the basis of and manner st | of examination and/or | investigation, in my | opinion, death occ | urred at the time, o | date and place, and | due to the cause(s) |
| | Vith Void | Σ | 29b. Signature and title of certifier | £ . 2 | 29c. Licens | se number | 2 | 29d. Date signed (A | fonth, Day, Year) |
| | 0, | | 20 Name and address of account | - MI |) DO | NP 308 | 5 | tebru | = 4 70 JUB |
| | 10 | | 30. Name and address of person who completed cause of a | | e, Print) | S+ 99 | n B | 1+ | MD 2 1771 |
| ń | Stat | e | | rar's ignature | 1 | 21 3 | 1 | -1.11/22/1 | |

DHMH 17 Rev 1/2001

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| | | | For State Registrar | State of Maryla | | artment of I | | | giene 2012 | 2 04869 |
|----------------|---|------------------|--|--|---------------------------|---|---|--------------------------------------|---|--|
| | Physicia | | 1. Decedent's Name (First, Middle, Last | t) | | | | 2. Date of Dear Month | th Day Year | 3. Time of Death |
| - | Medie Examir | | 4a. Facility Name (if not institution, give s | | | 4b. City, Town, or Catons | r Location of Deat | | 4c. County of Dea Baltin | th |
| | Funeral Director | | 5. Social Security Number 6. Se 219-01-6205 Usual Residence of Decedent | x | s. last birthday) Yrs, | If Under 1 Year Months Days | If Under 24 Hrs Hours Min. | | Year) Co | thplace (State or Foreign suntry) aryland |
| | Maryland 28a-f shov otified at | Director | MD Baltimo | | City, Town or Lo | cation nsville | | , | | 10d. Inside City Limits 1 ☐ Yes 2 ☒No |
| | h with the ns 23a or nust be n | Funeral D | 10e. Street and Number 717 Maiden Cho | ice Lane S' | г 208 | 10f. Zip Code 21228 | 3 | | 10g. Citizen of What Co | ountry? |
| 900 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | þ | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced | 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. | | Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🌠 No | ın, Mexican, Puer | pecify Yes or No- to Rican, etc.) | 14. Race - Ame Black, Whit | |
| 21215-0036 | vithin 72 hou lene. r than "natu the Medical | Completed | 15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12) | ucation de completed) College (1-4 or 5+) | (Give i | dent's Usual Occup kind of work done o O NOT use retired) | during most of wo | rking | 16b. Kind of Business | Industry |
| Maryland | 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "traumatic event, the Mec | To Be | 17. Father's Name (First, Middle, Last) George Ott | | | | 18. Mother's Na | me <i>(First, Middle, N</i> | /aiden Surname) | nder |
| e, Mar | and 2 shou Health and tem 27 is n | | 19a. Informant's Name/Relationship (Type Daniel Micari | / Nephew | 29 M | elinda La | | | City or Town, State, Zip 06010 | o Code) |
| Baltimore, | permit. Page 1 a Department of I- Important; If ite any injury or ot | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Disposition 1 Other (Specify, | Removal from State | | sition (Name of natory or other plac Crematory | | | 20c. Location - City or Baltimore, | |
| Baj | permit Depar Impor any in | | 21. Signature of Funeral Service License | <u> </u> | | . Name and Addres | ens Aven | ue, Balti | uneral Home imore, Mary | |
| - | Physician/ Medical Examiner | | 23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) | a. Due to (or as a conse | | er the mode of dying | g, such as cardiac | or respiratory arre | st, | Approximate Interval Between Onset and Death |
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| 3760 | ficate be of growing physicials as the bur | Aedical | • | d | | | | | | |
| . Box 687 | sician: The law requires that the death certificate be excertificate has been signed by the attending physician rector, page 2 should be detached for use as the burial | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown | 3c. If yes, outcome of pregr 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown | etal death 3 | Ectopic pregnanc Other (specify) | у | | 23d. Date of del Month | ivery Day Year |
| rds, P.O. | The law requires that the arte has been signed by the page 2 should be detach | ξ | Part II, Other significant conditions con | ntributing to death but not re | esulting in the u | nderlying cause giv | en in Part I. | 23e. Did tob 1 ☐ Ye | acco use contribute to | the cause of death? |
| Vital Records, | n: The law re ficate has bor, pr, page 2 sh | Completed | 25. Was case referred to medical | | | | | 24a. Was an autops perform | y prior to d | opsy findings available completion of cause of 2 No |
| /Ita | rsicia s certi lirecto | To Be | examiner? — | ospital: | 75000 | Otho | r: • Chec | | | |
| on of | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director, | Certificate: T | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | 1 Inpatient 2 28a. Date of injury (Month, Day, Year) | 28b. Time of injury | 28c. Injury work? | at | 28d. Describe how | nce 6 Other (Speci w injury occurred | fy) |
| Division of | ital or Atte urs after de ral Directo lled in by tl | | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At h building, etc. (Speci | ify) | | | City or Town, | · | 9 |
| : | the Hosp thin 24 hou the Fune mpleted fi | Medical | only one) Certifying Nurse | cian: To the best of my knower: On the basis of examinati Practioner: To the best of r | ion and/or investi | gation, in my opinior eath occurred at the | n, death occurred a time, date and pla | at the time date and | I place and due to the o | aucals) and manner stated |
| | o o o | | 29b. Signature and title of certifier CR | NP | | 29c. License | | 29 | 3d. Date signed (Month) $2/14/12$ | , Day, Year) |
| | | | 30. Name and address of person who cor | | | , | | | - | |
| l | State Registra | _ | 709 Maiden Cho 31. Date filed (Month, Day, Year) FEB 2 1 20 | 12 Jane Ca | tonsvil | le, Maryl | and 2122 | 2.8 | | |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Februani 9:05 A. M <u>Barbara A. Mulligan</u> Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2/2/38 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Director 220-36-3326 1 🗆 M 2 🔀 F 74 Maryland Usual Residence of Deced Show 10b. County the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f sh notified a MD Baltimore 1 Tes 2 X No Landsdowne 10e. Street and Number ò ms 23a or must be r 10g. Citizen of What Country? Funeral 3127 Freeway ral", or items 2 Examiner mus 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No Specify "natural" Completed 3 XWidowed 4 ☐ Divorced Specify: event, the Medical White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygie is marked other Clerical State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unknown Norman injury or other traumatic Emily Gribbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau William N. Mulligan / Son 3127 Freeway Landsdowne, Ma.yland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 2/21/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home _ ~ 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter ne disease, or conplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List of it one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): buria ding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month
1 Yes 2 No
9 Unknown for Pregnant at time of death Month Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 3 Probably 4 Unknown Completed 1 Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 certificate perform death? Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2/ No Hospita 1 Yes Other: Certificate: To Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden 5 \square Pending injury hours after death uneral Director: A Accident
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Contr Accident Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Hospital Medical

State Registrar 29a. Certifier

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge death anomalied the time, date and place and due to the cause(s) and manner as stated.

20/2

29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louise JANIAN05 Year 908 PM IANE 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin osedale Square HOSPITAL Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) **Director** 1 □ M 2 🕱 F 63 -30-MATY HOUD 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho. 10a, State 10h County 10c. City, Town or Location event, the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits KosedA 1 Yes 2 No 10g. Citizen of What Country? U.S.A 21237 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 🗷 No þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5A14 MAIN HARDRESSER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1
Department of Health and Menta.
Important: If item 27 is marked, any injury or other traumatic eve Mc CALL KINNETA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Loute Number, City or Town, State, Zip Code) TOM MARIANOS 926 Shipley LUSBAND 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 2-19-2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Censes 22. Name and Address of Facility OSIPL N ZANNINO JAFA. Balton, MD 21224 11.00 5+ 23a. Part 1. Enter the disease, shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) temorrhag Medical Due to (or as a consequence Examiner tens Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician s the burial Physician/Medical attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death Month igned by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Yes 2 No director, 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital Other: မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 2 Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 5 the Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) C. M. selles M.D D36663 02/15/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin square Drive Baltimore State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State | | State of M | laryland | | artment of I | | nd M | | 0.0 | | 01070 |
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| | _ | | Registrar 1. Decedent's Nam | ne (First, Middle, Las | at) | | Cer | tificate of L | Jeatn | | 2. Date of Dea | Reg. No. 2 | 12 | 3. Time of Death |
| | Physicia | | ARNOLI | | -7 | MICHA | ET. | | | | Hanth FClovus | | Year | 3. Time of Death |
| 1 14 | Medic Examir | | | f not institution, give | street and number) | 111 0111 | | 4b. City, Town, o | r Location of | Death | 1(0004 | 4c. County c | | 1,000 |
| Transfel . | <u> </u> | | | ILBURY RO | AD | | | BALTI | MORE | | | BALT | IMOI | RE |
| | Funeral | | 5. Social Security N | | | je (In yrs. last | birthday) | If Under 1 Year Months Days | If Under 24 Hours | 4 Hrs. Min. | 8. Date of Birt (Month, Da | th y, Year) | 9. Birthp Count | lace (State or Foreign |
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| | land shov d at | ρ | 10a. State | 10b. County | | 10c. City, T | own or Lo | cation | | | | | 1 | 0d. Inside City Limits |
| | Maryl 28a-f otifie | Director | MD | BALTIM | ORE | В | BALTIN | IORE | | | | | | 1 🗆 Yes 2 🔀No |
| | h the | a D | 10e. Street and Nu | | | | | 10f. Zip Code | | | | 10g. Citizen of W | hat Coun | try? |
| | ms 2; must | Funeral | | ILBURY RO | | 1 11 5 | Lie | 212 | | | | USA | | |
| 21215-0036 | s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | þ | 11. Marital Status1 ☐ Never Mar3 ☐XWidowed | ried 2 Married | 12. Was Decedent In Armed Forces? 1 Yes 2 If Yes, Give Year or Dates. | Ever in U.S. | l II | Vas Decedent of H Yes, specify Cuba | ın, Mexican, I | n? (Speci Puerto Ri | ify Yes or No- ican, etc.) | 14. Race Black Specify: | , White, e | |
| 2-0 | hour natur dical | olete | (90 | 15. Decedent's E | ducation | 1 | I I6a. Deced | ent's Usual Occup | ation | | - 4 | 16b. Kind of Bus | | |
| 21 | nin 72 ne. than " e Me | Completed | Elementary/Sec | | College (1-4 or 5 | | life. Do | ind of work done of NOT use retired) | • | | | | | |
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| ary | should and Me is mar raumati | | | ame/Relationship (7) | rpe, Print) | | | a Address (Street a | ESTI and Number | | Route Number | r, City or Town, Sta | rte. Zip C | NOVIG |
| | 4.43.2 | | JANET A | BRAMOWITZ | /DAUGHTER | | | 5 BANCRO | | | | | 2121 | |
| Baltimore, | e 1 and 2 of Healt If item 2 or other | | 20a. Method of Dis | | Removal from State | | e of Dispos | sition (Name of eatory or other place | | Da | | 20c. Location - 0 | City or To | wn, State |
| ţi | t. Pag tment tant: ijury o | | | 5 Other (Specif | | | | EL CEMET | | 2/19/ | /2012 | BALTIM | ORE, | MD |
| Bal | permit. Page 1 and Department of Healt Important: If item 2 any injury or other once. | | 21. Signature of Fu | neral Service Licens | ee | | | Name and Address | | DOI | | NSON & BE | - | |
| Н | | | shock, or hea | rt failure. List only o | olications that caused ne cause on each line | d the death. D | o not ente | r the mode of dyin | g, such as ca | ardiac or | respiratory arr | rest, | | Approximate Interval Between |
| | nysician/ Medical | | immediate Cause disease or condition resulting in death) | | a. Leukemi | | | Henem | 4 | 17.40 | 466 | | | Onset and Death |
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| | cate be executed physician and s the burial-transit | al E | resulting in death) | Last | Due to (or as | a consequend | ce of): | | | | | | | |
| 200 | ate be ohysic the b | edical | | | d | | | | | | | | | |
| 687 | | /Me | IF FEMALE: 23b. Was decedent | progrant | 23c. If yes, outcome | of pregnancy | | | | | | | | |
| Box | To the Hospital or Attending Physician: The law requires that the death certificate the 12st Abous after death. Within 2st hours after death. To the Functal Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a | Physician/M | in the past 12 1 Yes 2 Unknown | months? | 1 Live Birth 4 Pregnant a 9 Unknown | 2 Fetal de | eath 3 🗌 | Ectopic pregnanc Other (specify) | у | | | 23d. Date Mont | | ry Day Year |
| Division of Vital Records, P.O. | requires that the des been signed by the s should be detached | by | Part II. Other signif | ficant conditions co | ntributing to death b | ut not resultir | ng in the ur | nderlying cause giv | en in Part I. | | 23e. Did to | bacco use contrib | | e cause of death? |
| ord | v requ | Completed | | | | | | | | | 24a. Was a | an 24b. We | ere autop | sy findings available |
| 3ec | he law te has | luo | | | | | | | | | | med? de | or to con ath? ☐ Yes | npletion of cause of |
| a | ifci an: The certificate rector, pag | Be C | 25. Was case referment | | | | | 26. Pla | ace of Death | (Check o | 1 ∐ Yes nly one) | ZANOI II | ies i | Z - NO |
| <u>S</u> | Physic this ce al dire | ၉ | 1 🗆 Yes 2 🖠 | e NO | | ent 2 🗆 ER/ | | | 4 LI Nursi | ing Home | e 5 Resid | ence 6 Other | (Specify) | |
| n 0 | ding F h. After funer | Certificate: | 27. Manner of Deatl 1 Anatural | 5 Pending | 28a. Date of injui (Month, Day | | o. Time of injury | 28c. Injury work | at ? | - 1 | d. Describe ho | ow injury occurred | | |
| Sio | Atten | rţţi | 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide | Investigation 6 Could not be determined | 28e. Place of Inju | ırv - At home. | farm, stre | | Yes 2 N | - | of Location (S | treet and Number | or Rural I | Route Number |
| Ö. | al or a after s after al Dire | | 4 🗀 Homicide | determined | building, etc | . (Specify) | , - | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 20 | City or Town | | or riarari | iodie rambei, |
| | To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page | Medical | (Check 2 | Medical Examin | ician: To the best of ner: On the basis of ex e Practitioner: To the | xamination and | d/or investi | ation, in my opinio | n. death occu | irred at th | e time, date ar | nd place, and due to | the caus | se(s) and manner stated. |
| | To the within To the | 2 | 29b. Signature and | | e Fractitioner. 10 the | e best of my k | nowleage, | 29c. License | | and place | | 29d. Date signed (| | |
| | | | | | | |) | Į t | 73757 | 3 | | February | 19 | 2012 |
| | 18 | | | ess of person who co | ompleted cause of de | | a) (Type, Pr | n Ave | B | attha | ne-e | | 209 | |
| ı | Stat Registra | ~ | 31. Date filed (Monti | | | r's Signature | har | Kal | | | | | | |

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| linos Nicholas | | - For State | ate of Maryla | | artment of rtificate of | | and | Menta | al Hyg | | eg. No. | 20 | 12 | 0487 |
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| Physicia Physicia Physicia | ın/ | Registrar 1. Decedent's Name (First, Middl MINAS | e,Last) G. | | | - 1 | Vicol | las | 2 | Date of Dear Month February | th | Year 2 | 3. | Time of Death 0000 hrs |
| | | 4a. Facility Name (if not institution 3106 Rueckert Avenu | n, give street and nun | nber) | 4 | b. City, Tow Baltimo | | ocation of | Death | | 1 | ounty of D | eath | |
| Funeral | | 5. Social Security Number | | 7. Age (In yrs. I | ast birthday) | If Under | 1 Year | If Under | | 8. Date of Bir | | (YYYY) | 9. Birthp | place (State or |
| Director | | 216-62-6300 | 1XM 2F | 55 | б Yrs. | Months | Days | Hours | Min. | 10/22/ | 1955 | | Coun | try) MD |
| an y | ŀ | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, | , Town or Locati | on | | | | | | | | 0d. Inside City Limits |
| Maryland 28a-f show d at once. | ğ | MD N/A | | Bal | timore | 10f. Zip Co | - d- | | | - 14 | 0g. Citizer | n of What | | Yes 2 No |
| the Mary 1 or 28a iffed at | Director | 10e. Street and Number 3106 Rueckert Ave | nue | | | 2121 | | | | | • | S.A. | O Garrer | , . |
| eath with the Maryland items 23a or 28a-f sho ust be notified at onec. | Funeral | 11. Marital Status 1 X Never Married 2 M | | | | s Decedent es, specify (| | | | cify Yes or No Rican, etc.) | - 14 | I. Race - A White, e | | n Indian, Black, |
| hours after death with the Maryland natural", or items 23a or 28a-f sh. Examiner must be notified at once | | | 1 Yes | 2 X No | 1 | Yes 2X | No | specify: | | | Sp | pecify: | Wh | ite |
| hours a | ted by | 15. Decedent's Education (Spe Elementary/Secondary (0-12) | cify only highest grad | | 16a, Deceden during m | t's Usual Oo ost of workin | | | | | 16b. Kin | d of Busin | ess/Ind | ustry |
| 5-0036 led within 72 hours tygiene. other than "natur the Medical Exam | Completed | 12 | 4 | | Chore | ographe | | | | | | | ment. | /Education |
| | Be Co | 17. Father's Name (First, Middle Geonge | Last) | | Nico | olas | | 3.Mothers Irene | Name (| First, Middle, I | Naiden St | urname) | K | atogiritis _ |
| nore, MD 2121 siges I and 2 should be fi nt of Health and Mental I t: If item 27 is marked other traumatic event, | P | 19a. Informant's Name/Relations Michael P. Donnel | | In_l aw | | | | | | imore, M | | | State, Z | (ip Code) |
| | | 20a. Method of Disposition 1 X Burial 2 Cremation | | 20b. | Place of Dispos | ition (Name | of ceme | etery, | | Date | | | ity or To | own, State |
| Baltimore, permit. Pages 1 a Department of He Important: If its injury or other to | | 4 Donation 5 Other S | pecify: | SE C | crematory or oth | lame and A | _ | | | 2/2012 onar | | timore | | |
| Ball permit Depar Impo | | 21. Signature of Funeral Service | alg Bla | i | 53 | 05 Harf | ord | Road, | Balt | imore, M | D 2121 | 14 | | |
| Physician /Medical | | 23a. Part I. Enter the disease, or failure. List only one cause | on each line. | | | | dying, s | uch as car | rdiac or | respiratory arr | est, shock | ς, or heart | | Approximate Interval Between Onset and Death |
| ∠xaminer | | Immediate Cause (Final disease or condition resulting in death) | a. Atheroscler Due to (or as a | | | ease | _ | | | | | | \neg | |
| | ٦ | Sequentially list conditions, if any, leading to immediate | b Due to (or as a | consequence o | of): | | | | | | | | \neg | |
| ٠ := | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a | consequence o | of): | | | | | | | | _ | |
| be executed sician and urrial - transit | dical E | UNPENDED | d. AMENDED | | | | | | | | | | | |
| 760, icate be physici the buri | /Med | IF FEMALE: 23b. Was decedent pregnant in t | 23c. If yes, o | outcome of prec | | | 3/20 ₃ Г | 12,W | | 201 | | Date of de | elivery Da | v Year |
| Box 68760 e death certificate b the attending physi ed for use as the bu | Physician/Me | past 12 months? | 4 Pregn | ant at time of de | | tal death her (Specif | | Ectopic | pregnan | | " | ionui | Da | y |
| O, BC at the dez | | Part II. Other significant condi | 9 011010 | | resulting in the u | underlying c | ause gi | ven in Parl | t I. | | | | | e cause of death? |
| S, P. | ed by | Chronic Alcoholism | | | | | | | | 1 Ye | | | | bly 4 Unknown psy findings available |
| Cords, law require, has been see see see see see see see see see | Completed | · | <u> </u> | | | | | | | auto | osy orm <u>ed</u> ? | prid dea | | mpletion of cause of |
| tal Rec | Be Co | 25. Was case referred to medical examiner? | | | | 26 | | of Death (C | Check o | nly one) | | | | |
| of Vit. Physici | 유 | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date | npatient 2 of Injury | ER/Outpatient | | | Other 4 at Work? | | Home 5 28d. Describe | Residence how injury | | | Scene |
| ISION OF Attending Ph. er death. | ation | 1 Natural 5 Per | ding estigation (Month | , Day,Year) | | | 1 Y | es 2 🗌 I | | | | | | |
| _ <u>≥</u> | Certification: | 3 Suicide 6 Cou | | e of Injury - At h | nome, farm, stre | et, factory, c | office bu | uilding, etc | | 28f. Location (or Town, | | d Number | or Rura | al Route Number, City |
| To the Hospital Within 24 hours To the Funcral | | 29a. Certifier 1 Certifying I | Physician: To the bes aminer:On the basis of | t of my knowled | dge, death occu | rred at the ti | ime, dat | te and plac | ce, and | due to the cau | se(s) and | manner a | s stated | I. |
| To the within To the comp | Medical | one) 2 Medical Ex. 29b. Signature and title of certif | and manner s | tated. | and/or investiga | | | number | arred at | tile time, date | | | | h, Day, Year) |
| | | man | ~ ~ | | | | O.C.N | 1.E. | | | Febru | uary 15 | , 2012 | 2 |
| Q | | 30. Name and address of perso Ling Li, MD Assist | n who completed caus ant Medical Exar | | | re Street | , Balti | more, N | 1D 212 | 223 | | | | |
| Si | tate | 31. Date filed (Month, Day, Year | | gistrar's Signa | ture | arker | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monica Nwo1e ^{Day}6, February 20T2 7:51 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Director 217-87-2287 76 Yrs 1072574 Year) Nigeria Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Examiner must be notified MD Prince George's Greenbelt 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6160 Spring Hill Terr. #301 20770 Nigeria 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 27 No If Yes, Give Year or Dates. 1 ☐ Yes 2XX No Specify: 3 X Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ္ပ Nwosii Eherim Nwabuokwu Eherim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Bright / Daughter 5503 Randolph St., Hyattsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Nwole Mausoleum permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 04/28/2012 Umunoha, Imo, Nigeria 4 Donation 5 Other (Specify) Signature of Funeral Seprice Lizensee M00382 Rapp Funeral and Cremation Services Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death onger Medical resulting in death) Due to (or as a consequen of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has bairector, page 2 sl 24a. Was an performe 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminor? 2 🗌 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 No Accident Investigation 1 Yes 6 Could not be

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 filled in by the 24 hours after deat Funeral Director: сотрыетес within 2 To the

Baltimore, Maryland 21215-0036

Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and wie of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | 1 - For State Registrar | Otate of N | nai yiai ic | | tificate of D | | vientai mygie Rei | g. No. 201 | 2 04875 |
|---------------------------------|---|-------------------------|--|--|-------------------------------|---------------------|---|--|--|-----------------------------------|--|
| | Physicia Medi | | Decedent's Name (First, Middle | | Franc | cis No | taro, Sr. | | 2. Date of Death Month | 2 Day 2 O Year | 3. Time of Death 22:45 M |
| | Examir | | 4a. Facility Name (if not institution Esther's Place | | | | * . | Location of Death | | 4c. County of De | |
| | Funeral Director | | 5. Social Security Number 212-20-2351 | 1 X M 2 🗆 E | ge (In yrs. las | t birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Yo June 20 | a F | Birthplace (State or Foreign Country) Iaryland |
| | and show 1 at | į | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, | Town or Loc | ation | | | | 10d. Inside City Limits |
| | Maryla 28a-f notified | Director | | ltimore | | | | Edgemere | | | 1 ☐ Yes 2 🏝 No |
| | with the 23a or ust be r | Funeral D | 10e. Street and Number 6525 North Po | oint Road | | | 10f. Zip Code 21219 | | | g. Citizen of What C Inited St | • |
| 36 | e filed within 72 hours after death with the Maryland ital Hygiene. So dother than "hatural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | | 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorces | If Yes, Give | ? | 1 | √as Decedent of His Yes, specify Cubar | | | | nerican Indian, iite, etc. |
| 2-00 | Phours "natura dical E | plete | 15. Decede | Year or Dates. nt's Education est grade completed) | | 16a. Deced | ent's Usual Occupa | tion | . 16 | 6b. Kind of Busines | White ss Industry |
| Maryland 21215-0036 | ed within 72 Hygiene. other than ' | Completed by | Elementary/Seconday (0-12) 12 Years | College (1-4 or | 5+) | life. DC | ind of work done do NOT use retired) Employee | | ing | Automobil | |
| pu | filed w tal Hyg ed othe event, | To Be | 17. Father's Name (First, Middle, I | | | | | 18. Mother's Nam | e (First, Middle, Mai | iden Surname) | e bales |
| aryla | should be file h and Mental H 7 is marked or traumatic eve | - | Pietro Notar | The state of the s | -1 | 405 M-00- | | | ine Aiell | | |
| 3, Mô | 1 D = 0 | - 5 | Mrs. Josephine | M. Notaro | 18 | 6525 | North Po | int Road | al Route Number, Ci Baltimo | re, MD | Zip Code) 21219 |
| Baltimore, | t. Page tment o rtant: If rjury or | | 20a. Method of Disposition 1 | Specify) | . cen | neterv. crem | ition (Name of atory or other place Forest V |) i | | oc. Location - City of Owings | or Town, State Mills, MD |
| Bal | permi Depar Impor any in | ij | 21. Signature of Funeral Service L | icensee / | | ²² I | Name and Address | Fulleral | Home of | Dundalk, | Inc. |
| 7 | Ph, sician/ Medical Examiner | ər | 23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, | Due to (or as | e. 5 & Y (a consequen | Do not enter | the mode of dying | , such as cardiac o | or respiratory arrest, | <u>ry rang</u> | Approximate Interval Between Onset and Death |
| 8760 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | dedical Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or linijury that initiated events resulting in death) Last | cDue to (or as defined by the control of th | | | | | | | |
| Box 687 | the death certific y the attending p iched for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 Fetal d | eath 3 🗌 | Ectopic pregnancy Other (specify) | | | 23d. Date of de Month | elivery Day Year |
| Division of Vital Records, P.O. | w requires that s been signed t should be deta | Completed by P | Part II. Other significant condition | ons contributing to death by | 1 | ing in the un | | n in Part I. Thy Ha | | 2 □ No 3 □ F | o the cause of death? Probably 4 Unknown utopsy findings available |
| Rec | The la | Som | | | | | | | autopsy performed 1 2 Yes 2 | prior to death? | completion of cause of |
| /ital | Physician: The law this certificate has al director, page 2 ! | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | 0 🗆 50 | | Other | e of Death (Check | | 5 5- | Her's Place |
| on of | nding Phy ath. r. After this ie funeral c | Certificate: T | 27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig | 28a. Date of inju (Month, Day | ent 2 ER ry 28 y, Year) | b. Time of injury | 28c. Injury a work? | | me 5 Residence 28d. Describe how in | | Leving |
| Division | tal or Atters ar safter de al Directo ed in by the | | 3 Suicide 6 Could r 4 Homicide determi | | | e, farm, stree | t, factory, office | | 28f. Location (Street City or Town, St | | ural Route Number, |
| : | the Hospi thin 24 hou the Funer mpleted fill | Medical | only one) 3 Certifying | Physician: To the best of xaminer: On the basis of e. Nurse Practioner: To the | xamination an | nd/or investig | ation, in my opinion, ath occurred at the t | death occurred at ime, date and place | the time date and no | are and due to the | cause(s) and manner stated |
| | | | 29b. Signature and title of certifier | Rebre | | | 29c. License r | | | Date signed (Mont | _ |
| | 5+1 | | 30. Name and address of person w | | | (Type, Pri | to Eo. | stern | Ave. | Baltin | 3,2012 405e,MD 21224 |
| | State Registra | ~ | 31. Date filed (Month, Day, Year) | 1 2012 32. Registra | ar's Signature | 1. Se | raplas | | | | 21224 |

NOTARO

RAYMOND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nea 100 m 65 February 0)57A Medical 2012 4a. Facility Name (if not institution, give **Examiner** 4b. City, Town, or Location of Death 4c. County of Death hmore Hospita CIT If Under **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months 265-45-3747 Hours Country) Director 1**X**] M 2 □ F 48 Usual Residence of Decedent Oct. 15, 1963 Florida or 28a-f show notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Harford 1 Yes 2 No Forest Hill 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 2039 River Downs Ct. 21050 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) er than "natural", or iter the Medical Examiner 14. Race - American Indian, þ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Disabled other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harley William Neal permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Fleda Moree Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2039 River Downs Ct., Forest Hill, MD 21050 Dennis L. Neal / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 📭 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-18-2012 Evergreen Cemeterv Panama City, FL Sign Tre If Funeral Pervice Licen 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and I for use as the burial-trans! Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No been signed by the a should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗌 No ☐ Yes 2 X No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death I Director: After the din by the funeral 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hor To the Fune completely f 29a. Certifier (Check Medical Examiner: On the basis or examination and/or investigation, in this openion, detail of the cause (s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

OHMH 17 Rev 06-2011

State Registr<u>ar</u> THOMA

Day 2

31. Date filed (M

600N Wafe St. Baltimore NO 21287

OWS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KO

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day2012 Year Richard £65 18, Lee Owen Sr 11:45A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2050 Bayside Beach Road Pasadena Anne Arundel 8. Date of Birth
(Month, Day, Year)
Aug 15,1950 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Days Hours 217-52-3625 Maryland 61 Director Usual Residence of Decedent show 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 212 No Maryland Anne Arundel Pasadena 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2050 Bayside Beach Rd 21122 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: white "natural", 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 auto mechanic <u>auto</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles R Owen Virginia Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Linda L Owen 2050 Bayside Beach Road Pasadena MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery ! 2/23/2012 Glen Burnie Maryland 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CROHNS DISTASE Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ METASTATIC ADENOCARCINOMA Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed UNDETERMINED ORIGIN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 ☑ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2/21/ 12 1336 Ru

Registrar

DHMH 17 Rev 7/2009

State

BOZE RITCHEE HWY, SVITISIZY PASADETUA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death [□]15, 2012 Physician/ W. February 3:55 A M Helen Oxenham Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Sunrise of Silver Spring Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 577-10-6788 **Director** 1 M 2 X F 93 October 30, 1918 Washington, D.C. Usual Residence of Deced 28a-f show 10a. State 10c. City, Town or Location 10d, Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at the Maryland Director 1 🗆 Yes 2 🗶 No Montgomery Silver Spring Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 1102 Broadmore Place United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental F is marked o ဂ္ Juliet Winfield W. Frederick Weitzel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1102 Broadmore Place, Silver Spring, Maryland 20904 item 27 John W. Oxenham / Son or other 20a. Method of Disposition
1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth February Bethesda, Maryland Montgomery Crematorium, Inc 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Pette Burans Mess M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 23a. Part 1. Years Immediate Cause (Final Physician/ Dementia of Alzheimer's Type disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 2 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure to Thrive, Malnutrition 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X No 2 No certificate 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Assisted examiner? Hospital Other: 1 ☐ Yes 2 🛣 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Living 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be To the Hospital or Atter within 24 hours after ded To the Funeral Director completely filled in by th Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

DHMH 17 Rev 06-2011

Registrar

(Check

only one)

29b. Signature and the of certifier

SMUOUN

Shyamsundar Rajan,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2. Registrar's Sign

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D53367

9801 Georgia Avenue, #117, Silver Spring, Maryland 20902

29d. Date signed (Month, Day, Year)

February 16, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>ebruary 16, 2012</u> 8:26 P. Shirley May Parrish Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 434 Underwood Circle Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days May 29, Year) 1936 Hours Maryland Director 214-34-4588 1 🗆 M 2 🔀 F 75 Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 ☐ Yes 2xxNo Maryland Harford Bel Air 20 10f. Zip Code 109. Citizen of What Country? 23a must l 21014 United States 434 Underwood Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force , o. Black, White, Completed by 1 Never Married 2 Married 1 Yes 2XXNo Maryland 21215-0036 White 1 ☐ Yes 2 Ϊ No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry than " Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) School Bus Attendant Board of Education 10 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) and Mental P ည Carrie Shew John E. Bissell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Main Street Whiteford, Maryland 21160 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Linda Bohdel / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb. Date 21, Burial 2 Cremation 3 Removal from State Highview Mem. Gardens ☐ Donation 5 ☐ Other (Specify) 2012 Fallston, Maryland 21. Signature of uneral Service License Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate nterval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ pulmonary disease hronic obstructive 4 cars Medical resulting in death) **Examiner** Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, The law requires Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Tyes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Division Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Medical To the Fune completely f 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Xido Melicol D 34208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3718 NORRISHUS KO, STEC, VARRETTSHILLE M 2/084 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

100

| 12-01392 Eddie Ray Petree, J | r. | ype or Print in Bla e State of Maryland / I | Departme | nt of Health ar | | | gible. | 12 0100 |
|--|--|--|--------------------|--|-----------------------------|------------------------------------|----------------------------|---|
| | 1- For State Registrar | | Certifica | te of Death | | | teg. No. ∠ U | 112 0488 |
| Physician/ Medical Examiner | Decedent's Name (First, M | ddle,Last) Eddie | Ray | Petree J | r | 2. Date of De Month February | Day Year 16, 2012 | 0927 hrs |
| | 4a. Facility Name (if not instite Baltimore Washing | | | 4b. City, Town, o | | f Death | 4c. County o | |
| Funeral Director | 5. Social Security Number 214–92–2084 | 6. Sex 7. Age (| In yrs. last birth | Months Da | _ | Min. | irth(MM/DD/YYYY) 3/1978 | 9. Birthplace (State or Foreign Marylan |
| ryland «-f show any if once. Ctor | Usual Residence of Deceden 10a. State 10b. Cour Maryland Ani 10e. Street and Number | | Pasade | | | | 10g. Citizen of Wh | 10d. Inside City Limits 1 Yes 2 No at Country? |
| e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 23a-f show or transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | 11. Marital Status | 7870 Bussenius | | 13. Was Decedent of H | | in? (Specify Yes or N | | - American Indian, Black, |
| s after death with t ran", or items 23s iner must be not by Funeral | | Married Armed Forces? 1 Yes 2 X Divorced If Yes, Give Year or Dates: | No | If Yes, specify Cuba | an, Mexican, lo specify: | Puerto Rican, etc.) | White Specify: | white |
| 1215-0036 d be filed within 72 hours afte fental Hygiene. tracked other than "natural", revent, the Medical Examines vent, the Medical Examines be Completed by | Elementary/Secondary (0- | specify only highest grade compl |) di | ecedent's Usual Occup uring most of working lif | | | 16b, Kind of Bus | |
| 5-0036 iled within 7 Hygiene, I other than the Medical | 12 | | sa | lesman | Tions II | No. of Control of the | produ | |
| D 21215-003 should be filed within and Mental Pygiene. 7 is marked other the market other the Mental Pygiene. To Be Comi | 17. Father's Name (First, Mid Eddie | R Petree | | | Bar | s Name (First, Middle, bara | Н | lewing |
| MD 21 2 should h and Me 27 is ma To | 19a. Informant's Name/Relati Eddie Petre | | | Mailing Address (Stre 70 Busseni | | | 1D 21122 | |
| 2 8 2 ± 4 | | tion 3 Removal from State | cremato | Disposition (Name of c ry or other place) [aven Cemeto | • | Date 2/24/2012 | | city or Town, State Surnie Maryland |
| Baltimor permit. Pages Department of Important: 11 injury or othe | 21. Signature of Funeral Serv | | 1 | 22. Name and Addre | ss of Facility | | s Funera | l Home P.A. |

23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Physician Medical Examiner

failure. List only one cause on each line.

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

Be Completed by

Medical Certification: To

State Registrar 2 [

3

Natural

Suicide

Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who comp

Theodore M. King, Jr., MD.

Pending

Could not be

Investigation

determined

fd 2-16-12

and manner stated.

(Specify) Residence

TR. ause of death (Item 23a)

32. Registrar's Signature

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| Immediate Cause (Final disease a. | Narcotic (Heroi | n) Intoxica | tion | | | | Dealii |
|--|---|----------------------------|---|-----------------------------|-----------------------------|---------------|-----------------------------|
| or condition resulting in death) | Due to (or as a consequence of | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of | | | | | | |
| X UNPENDED | AMENDED 23a, 27, 2 | 8a-f,per m | e,g925 3-14-1 | 2 sm | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pregrit 1 Live birth 4 Pregnant at time of de | 2 Fetal death | | ncy | 23d. Date of deliv Month | ery Day | Year |
| Part II. Other significant conditions | contributing to death but not re | esulting in the underlying | g cause given in Part I. | | cco use contribute | | |
| | | | | 24a. Was an autopsy perform | prior t | o completion? | dings available of cause of |
| 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 | ER/Outpatient 3 1 | 26.Place of Death (Check of DOA Other Nursing | | esidence 6 Ot | her: | |
| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe ho | w injury occurred | | |

fd 7:40 am

29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ORIGINAL

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

28e. Place of Injury - At home, farm, street, factory, office building, etc

1 Yes 2 X No

29c. License number

O.C.M.E.

COME

unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State) 8470 Bussenius Rd. Pasadena, Md.

February 17, 2012

29d. Date signed (Month, Day, Year)

Approximate Interval

Between Onset and

Death

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Teb 18, 2012 Physician/ Month Michael J. Patronagio 7:00 A Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7784 Montgomery Muse Ct. Severn Anne Arundel Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs, last birthday) **Funeral** Days Min Hours Director 1 **XX**M 2 □ F 355-07-5438 93 July 21, 1918 IL Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland items 23a or 28a-f sho er must be notified at Director XX Yes 2 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7784 Montgomery Muse Ct. 21144 USA 12. Was Decedent Ever in U.S. Armed Forces?

↑ ★조 Yes 2 □ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2xxNo Specify "natural", 3 XXVidowed 4 Divorced Specify Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Assembler Commericial Appliance Be traumatic event, 17. Father's Name (First, Middle, Last) permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic even once. 18. Mother's Name (First, Middle, Maiden Surname) ျှ Francesco Patronagio Francesca Syracusa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol J. Culver Severn, MD 21144 Baltimore, 7784 Montgomery Muse Ct., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1xx Burial 2 Cremation 3 Removal from State Crownsville Veterans Cemetery Feb 22, 2012 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Lice se Sign 22 Name and Address of Facility Fink Funeral home, P.A. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final taller Phonician/ 2disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should b Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate | 2 HNG 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Director: After this of in by the funeral director 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse-Rractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 38 2-20-12 8

DHMH 17 Rev 06-2011

Registrar

michael

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#6perFH, G924, 2/21/2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4.15 P M 2. Date of Death Jessie Lee Perry Physician/ Month 02 Day 2012 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAUTIMORE HOSPICE GILCHRIST If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Hours 216-28-7491 **Director** 1 🔀 M 2 🗶 F 80 Yrs. 12-02-1931 "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 X Yes 2 ☐ No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 3822 EVERGREEN AVENUE Funeral 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2X No 1 ☐ Yes 2 X No Specify: BLACK 3 X Widowed 4 □ Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) HUTZLER RETAIL 12 2 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JESSIE BISHOP ALICE LEE GATLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 3822 EVERGREEN AVE. BALTIMORE, MD. 21206 YERRY- CHUNG (OTR) LAUdette 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ■ Burial 2 Cremation 3 Removal from State 2/28/12 BALTIMORE, MD GARRISON FOREST 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGITN GREENE FUNERING SCVS 4905 YORK ROAD. BALTO, MD. 21212 7.F 1101553 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ HCART :0NGOSTUVO disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): death certificate be executed burial-tra Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 the. attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE PULMONARY To the Hospital or Attending Physician: The law requires the within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy DOMENTIA 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) **Division of Vital** Hospital: Other: 2 100 မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, greating occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title_of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year, State FEB 2 1 2012 Registrar

Box

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 20,2012 7:35 A. M Jeanette M. Palmere Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris 5. Social Security Number 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) If Under 8. Date of Birth (Month, Day, Year) **Funeral** 219-32-9602 **Director** 75 1 □ M 2 🛛 F Yrs Maryland 10-23-1936 Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Examiner must be notified Nottingham Md. Balto. 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral USA Nottingham, Md. 21236 8378 Cypress Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. b 1 Never Married 2X Married 1 Yes 2 If Yes, Give Year or Dates. White 1 ☐ Yes 2 X No Specify Specify Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Lonce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosalie Mossmiller Francis Gier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8378 Cypress Mill Road Nottingham, Md. 21236 19a. Informant's Name/Relationship (Type, Print) Spouse Nicholas Palmere Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 Surial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State 2-23-2012 Balto.Md. Gardens of Faith Donation 5 Dother (Specify) Schimunek FuneralHome, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Nottingham, Md. 21236 1110 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Directly (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 X No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗶 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

(Check

29b. Signature and title

JACKIE JONES,

CRNP

2300 DULANEY VALLEY RD.

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year) 20

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 20:38 PM PERRINE ANGELA FEBRUARY 16 2012 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year 216-20-491 1 □ M 2 🗗 Days YIVANIA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. Counts 1 Yes 2 No MORE MARYLAND 10g, Citizen of What Country? 10e. Street and Number 10f. Zip-Code 5 U. 21222 KOAd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 3 ₩idowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 160551 11910 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Codg) 19a. Informant's Name/Relationship (Type. Print) SAltiMONE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb RUARY 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility W. DABRONSK: ChoJNACK: Funeral Homes P. A. 1005 Dundak Ave. BAIT: MORE, MARY LAND 2 1224 Approximate Interval Between Onset and Death 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PERICARDIAL TAMPONADE disease or condition resulting in death) Due to (or as a consequence of) 8 YEARS ANEURYSM Sequentially list conditions, if any, loading to influence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last GORTIC Disk to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Onknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 2 🖃 No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show a notified at

ral", or items 23a or Examiner must be n

"natural"

marked other than

S

Department of Health a Important; If item 27 Is any Injury or other trau

Injury or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be and Mental Funeral Director

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Completed

Be

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ician and burial-transit attending physician detached for use as the the ģ page 2 should be certificate has filled in by the funeral director, Director; After

Physician/Medical

þ

Completed

Be

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Certification:

Medical

examiner?

27. Manner of Death 1 ☑ Natural

2 Accident 3 Suicide

one)

1 ☐ Yes 2 ☑ No

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

or Attending

the

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death.

after Hospital within 24 hours a

in the past 12 months? HYPERTENSI ON

> Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 28b. Time of 5 Pending investigation

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 🗌 Yes 2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4940 Eastern Avenue, Baltimore, MD, 21224

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 29a. Certifier (check only

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie MD

6 Could not be

29c. License number 00069127

FEBRUARY 16 2012

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PH AM

LIEM ANH 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Year Feb. Helen Palmieri 11:20a4 16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Belair Upper Chesapeake Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Hours 213-18-7306 Director 1 □ M 2 🕱 F 90 Maryland 7-13-1921 Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 422 S. Bouldin Street USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates. White 1 ☐ Yes 2 X No Specify. "natural" Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) In own Home Homemaker Be aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is many injury or other. Enrico Paulino Molly Comi 19a. Informant's Name/Relationship (Type, Print) daughter | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Manfre 1533 Cedarwood Dr. Belair, MD. 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 2/20/2012 | Baltimore, MD Oaklawn 4 ☐ Donation 5 😿 Other (Specify) entomb. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Joseph N. Zannir 263 S. Conkling St.Baltimore, Zannino, more, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, i i.n Bevere disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

Within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burn IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown lesterolemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 🛣 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Proctific har: Enthy best of my front dgs. death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) D0068014 2/16/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N 75 21 N J HUB , 500 CHESAPEAKE DR BEL AIR MD 21014 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2:00 P M Velma Peri Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2525 Pot Spring Road, Baltimore Apt L404 Timonium Funeral Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min Director 214-26-7442 1 □ M 2 🗓 F 1929 83 Jan. 12, Maryland Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2X No Marvland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Road, Apt L404 21093 U.S.A death 12. Was Decedent Ever in U.S. Armed Forces 2

1 Yes 2 No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Giovanni Rocchi Antonia Giannerini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Peter L. Peri Husband 2525 Pot Spring Road, _Apt_L404 Timonium, Maryland 20b. Place of Disposition (Name of Duranies, crevally Seyher place)
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Spelightombment 2-22-2012 Timonium Maryland Ruck Towson Funeral Home, Inc. gna ure of Funeral Service Licenses 22. Name and Address of Facility au 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and 0 at th Immediate Cause (Final Physician/ 0 disease or condition resulting in death) a Medical Due to (or as a consequence of) Examiner squentially list eunditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician Physician/Medical P.O. Box 68760 the as IF FEMALE JSe a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2-2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an is certificate has be director, page 2 s autopsy performed? Yes 2 No Hospital or Attending Physician: The VELMA PERI this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) Nursing Home 5 \(\text{Plantage} \) Residence 6 \(\text{Dother} \) Other (Specify) Hospital: 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one) Certifying Nurse Practitioner: Jothe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

FEBRUARY 19,

31. Date filed (

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

29b. Signature and title of certifier

ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

pru ar

TIMONIUM, MD 21093

2012

only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 2 1 2012

Director

Funeral

Be Completed by

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Examine

Be Completed by Physician/Medical

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Certificate:

Medical

Physician/

Medical

Examiner

Funeral

Director

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| For State | | State C | ı ıvıaryla | | • | nent of I | | and N | nental Hyg | | 0 - | 1.0 | | |
| Registrar 1. Decedent's Name (First, A | Middle, Last) | | - | | - | | | | 2. Date of Deat | | 20 | +2 | 3. Fime | of Death |
| Donald | ЭТ. 🤉 | Quigl | ey Sr | | | | | | Feb 16 | Day 2 | 012 | Year | 14 | :39рм |
| 4a. Facility Name (if not institu | tution, give st | reet and nun | nber) | | 4b. | City, Town, c | r Location | of Death | | 4c. (| County o | of Death | | |
| Carroll H | | | | | | | mins | | | | arr | | | |
| 5. Social Security Number 154-24-806 | 6. Sex | K M 2□F | 7. Age (In yrs. | | rs. Mor | Inder 1 Year oths Days | If Under Hours | Min. | 8. Date of Birth (Month, Day, 3 – 21 – 1 | | | 9. Birthpl Counti PA | | te or Foreign |
| Usual Residence of Deceder | | | | | | | | | 13-21-1 | 752 | | | | |
| 10a. State 10b. Co | | . 7 7 | 10c. C | ity, Town o | or Location | | | | | | | 10 | | e City Limits Yes 2 \Boxed No |
| 10e. Street and Number | Carro |) T T | | | Lin | Mes f. Zip Code | tmin | ster | | O- Oiti- | | (h - 4 O 4 | | Yes 2 □ No |
| 95 Timber | Rido | je Dr | • | | 10 | | 2115 | 7 | | • | USA | hat Count | ry? | |
| 11. Marital Status | 1 | 2. Was Dece Armed Fo | dent Ever in U | .s. | 13. Was D | ecedent of H | lispanic Ori | igin? (Spe | ecify Yes or No- Rican, etc.) | 1 | | - America | | |
| 1 Never Married 2 X | | 1X Yes If Yes, Giv | 2 No e | | | es 2 🔀 No | | | ,, | s | | k, white, et whit | | |
| 3 Widowed 4 Dive | orced ecedent's Edu | Year or Da | | 160 0 | | Usual Occur | | | | | | | | |
| (Specify only | highest grade | e completed) | | 1 (0 | Give kind o | f work done Tuse retired, | during mos | t of worki | ing | 160. Kin | a ot Bus | siness Indi | ustry | |
| Elementary/Seconday (0- | -12) | College (1 | -4 Or 5+) | | | ente | | | | Con | str | ucti | on | |
| 17. Father's Name (First, Mic Charles Q | | ÷У | | | | | | | e (First, Middle, N Lomans | 1aiden Si | urname) | | | |
| 19a. Informant's Name/Rela | tionship (Type | e, Print) | | 19b. N | Mailing Add | dress (Street | and Numb | er or Rura | al Route Number, | City or T | own, Sta | ate, Zip Co | ode) | |
| Eleanor Qu | igley | -wife |) | 95 | Timk | er R | idge | Dr. | ,Westm | inst | ter | , MD | 211 | 57 |
| 20a. Method of Disposition 1 Durial 2 Crema | ation 2 🗆 🗆 | omoval from | | Place of C | Disposition crematory | (Name of or other pla | ce) | | Date | 20c. Loc | ation - (| City or Tov | vn, State | |
| 4 Donation 5 Ot | | erilovai iroiti | | | Carr | coll | Crem | | 7-12 | | | | | |
| 21. Signature of Funeral Ser | vice Licensee | tille | 111_ | | 1 | | | | tcher Westmin | | | | | 7 |
| 23a. Part 1. Enter the disease | se, or compli | cations that o | aused the dea | ath. Do not | | | | | | N. 120.00 | | | Approxir | nate |
| shock, or heart failure. Immediate Cause (Final disease or condition | List only one | Cause on ea | oneui | non | ua | | | | | | | | Interval I Onset ar | nd Death |
| resulting in death) | C. | Due to | or as a conse | ence f) | 1 | | | | | | | | | |
| Sequentially list conditions, | b | | enal | 10 | uu | re | | | | | | _ | | |
| cause. Enter Underlying Cause (Disease or linjury | < | Jueto | LLAN-O | CC | in C. | N | | | | | | | | |
| that initiated events resulting in death) Last | c | Due to | or as a conse | quence of) | : | | | , | | | | | | |
| | C a | V | enoi | 15 | thr | emb | uen | rbo | lic de | 000 | we | | | |
| IF FEMALE: | | ta Musa aut | | | | | | | | | | | | |
| 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | 1 🔲 Live | come of pregr Birth 2 Fe nant at time of nown | tal death | | ppic pregnan er (specify) _ | су | | | 2 | 3d. Date Mon | e of deliver th (| у Эау | Year |
| Part II. Other significant co | nditions con | tributing to d | eath but not re | sulting in | the underly | ing cause gi | ven in Part | l. | 23e. Did tob | acco us | e contrib | bute to the | e cause o | of death? |
| | | | | | | | | | 1 □ Y€ | es 2 🗆 | No : | 3 Proba | ably 4 | Unknown |
| | | | | | | | | | 24a. Was ar | | 24b. W | ere autop | sy finding | gs available of cause of |
| | | | | | | | | | perform | ned? | de | eath? | | |
| 25. Was case referred to med examiner? | | | | | | | lace of Dea | th (Check | | | | | | |
| 1 Yes 2 No | Ho | | Inpatient 2 | | | | 4 ∐ N | ursing Ho | me 5 🗆 Reside | nce 6[| Other | (Specify) | | |
| 2 Accident In | ending nvestigation | 28a Date (Mon | of injury th, Day, Year) | 28b. Tin inju | | 28c. Injur worl | | | 28d. Describe ho | w injury | occurred | d | | |
| 3 Suicide 6 C | could not be etermined | | of Injury - At h | | n, street, fa | ctory, office | | , | 28f. Location (Str City or Town | | Number | or Rural F | Route Nu | mber, |
| (Check 2 Medi | ical Examine | r: On the bas | is of examinati | on and/or i | nvestigation | n, in my opini | on, death o | ccurred at | d due to the caus the time, date and e, and due to the | d place, a | and due | to the caus | se(s) and | manner stated. |

a) (Type, Print)
At., Westminster, MD Z1157

29d. Date signed (Month, Day, Year)

2-16-2012

Registrar

DHMH 17 Rev 7/2009

MD

Stores

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BINU Chacko 12-1 Storce Au., h

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b State FH/May And / 28030 Haer Hof Health and Mental Hygiene 2 amend items 16a, b per fh g925 3-2-12 yt

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 6:45 PM Joyce 2012 Medical Roberts 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 21nailtospital NA ltimore 1timore Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** SOVEE **Director** 212-60-6792 1 □ M 2**X**□ F 58 06-29-53 MD Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD NA Baltimore ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 21215 2926 Edgecomb Circle South USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or itel Race - Affection Black, White, etc. African Armed Forces? 1 Never Married 2 Married þ 1 ☐ Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: American Completed 3 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kin**Behdifer**/li**Frield** (Give kind of work done of life, DO NOT use retired) during most of working Bendit Field Bendix Technical Elementary/Secondary (0-12) College (1-4 or 5+) the Technician Writor Writer 12th Grade Engineer Engineer 2vrs of Health and Mental Hygie item 27 is marked other other traumatic event, the Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Phyllis Clinton Frank Α. Wise of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19**2 ឬ១)ស្ង**g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)212152936 Edgecomb Circle South Baltimore, MD Phyllis A. Ford-Mother Department of Healt Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-23-12 Mem. Randallstown, MD 21. Signature of Fundal Se Jos Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore, MD 21217 638 N. 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of Examiner toni Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown CNA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Renal Viscase 1 Yes 2 X No Yes 2 N completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: ၉ 1 Deinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending injury 2 No 1 Yes after death Director: 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortiner 29c. License number 2012 -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBB. 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Strong to

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. Randolph 6:30P M Pauline 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore Future Care Irvington Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours 02-13-30 1 🗆 M 2 🔀 MD Director 212-30-9941 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4919 Frederick Avenue Apt D 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. African 1 Never Married 2 Married Yes 2 XNo altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: American 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Home maker Dom estic 12th Grade NΑ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ G reen Robert Mason Viola 19a. Informant's Name/Relationship (Type, Print) Daughtet19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. 1001 Spring Gate Road Apt. #2A Catonsville Smith Francine 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any Injury or o ō cemetery, crematory or other place)

L. Zion Cem. 1 NBurial 2 Cremation 3 Removal from State 02 - 24 - 12Mt. Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Wylie Funeral Home P.A. Street Baltimore, MD 21217 638 Ν. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Immediate Cause (Final ALUTE Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed after death. the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ⊅ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMENTIA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 N death? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Hospital Medical 29a, Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 registrar's Signature facel

21227

MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Februar Kabinson Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 62 99 1th more N Birthplace (State or Foreign Country) ocial Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** 1 M 2 D F Months Days April **Director** Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh t be notified a 1 Nes 2 No Honore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ritems 23a oner must be 2 VO 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner any injury or other traumatic event, the Medical Examiner. Black, White, etc. Completed by 1 Never Married 2 Married 1 Ves If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) echnician Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname, ည Kobinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ania 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility invoral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as drdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No g Unknown 9 Hinknown Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform this certificate Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 🗆 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I Natural 5 Pending 1 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractionars at the best of my knowledge scatt contend at the time date at place, and due to the cause(s) and manner at attemption of my knowledge scatt contend at the time, date and place, and due to the cause(s) and dinament at the time. 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) (Type, Print) 2(2) 31. Date filed (Month, Day, Year) Pegistrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#4a perPHYS G924, 2724/2012, WS State of Maryland Department of Health and Mental Hygiene 2011 2 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 9:31 February АМ Ross Patricia Medical Facility Name (if not institution, give street and number)

Brightview Assisted Living
Brightwood Retirement Community 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days 519-12-4238 1 □ M 2 🛛 F Director July 19,1925 Texas 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State must be notified at Director 1 ☐ Yes 2 🄀 No Timonium Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 23a U.S.A. 21093 12261 Roundwood Road permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Own Home Homemaker Be (18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Wells Irene Mae Alfred Hagan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lutherville, Maryland 21093 18 Oak Tree Court <u>Christopher Ross</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp | 2-16-2012 Towson Maryland 4 Donation 5 Other (Specify) Pature of Funeral Service Licensee Ruck Towson Funeral Home, 22. Name and Address of Facility 21204 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 s, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy

Secondary at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Medical Certificate: To 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ingeborg E. Stolz 9:10 РΜ February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Franklin Woods Center Rosedale Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 □ M 2 🛛 F 216 44 0949 85 Jan. 19, 1927 Germany Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 🗌 Yes 2 🌁 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2201 Redthorn Rd. 21220 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married ò 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates if Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical other traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Karl Eichel Margarete Habel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15 Kincaid Ct. Baldwin, Maryland 21013 . Page 1 and 2 sl ment of Health a tant: If item 27 is Rosemarie Fletcher (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 2/21/2012 Bayview Crematory Inc. Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) Sinture of Funeral Service Licensee 2 Name and Address of Facility Bruzdzinski funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 man. gart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line ROSCLERONC KEART Immediate Cause (Final DISEASE Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-transit Due to (or as a consequence of): Physician/Medical certificate be Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Ď Pregnant at time of death Month Day Year detached the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate Yes ours after death.

eral Director: After this certific filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မှ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work' Investigation 6 Could not be 2 🗌 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Registrar DHMH 17 Rev 7/2009

State

within 24 hours a

To the Funeral C

Medical

29a. Certifier

(Check

31. Date filed (Mo

29b. Signature and title of certifier

address of person who completed cause of de

ath (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month.

SQUARE DR, BALTIMORE

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

FRANKLIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 **1 –** For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 17, Lyndall S. Scherer 11:40a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Street <u> Hart Heritage</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral Director** 1 🗆 M 2 🔀 F 214-18-7156 91 11/9/1920 Maryland Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Yes 2X No Whiteford Maryland Harford o 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral must USA 21160 1505 Kerr Road within 72 hours after death , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Examiner Armed Force þ 1 Never Married 2 Married 1 Yes 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white "natural", 3 ₩ Widowed 4 □ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the DuPont secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Theodore Schneider Hazel Naomi Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1505 Kerr Rd., Whiteford, MD 21160 J. Renee Hodge (Step Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Harford Memorial Gdns. 2/22/2012 | Aberdeen, MD 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Signature of Funeral Service Licenses Aberdeen, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ OBSTRUCTIVE (HIONIL Medical resulting in death) Examiner Sequentially list conditions, Divirto (or as a nonsequence of cause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last as the burial-tran and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 1 Yes 2 No 1 🗌 Yes the Hospital or Attending Physician: 25. Was case referred to medica To Be 26. Place of Death (Check only one) 100 examiner? 1 Yes CANE 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? To the Hospital or Attending F within 24 hours after death.
To the Funeral Director, After t 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 735889 February 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Be/ D.R MD SPANUS 615 W. MPCPhoil ALFRAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Registrar

29b. Signature and title of certifier

cause of death (Item 23a) (Type, Print)

29c. License number

00047056

15 EASE MELVOSE AVE ZIZIZ

29d. Date signed (Month, Day, Year)

12-01137 Brian Shaw amend Item#1.per me.g925 3-8-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ian Shaw | | State of Maryland / Department of Health and Mental Hygiene 1-For State amend #7 Per FH G925 erifficate of Death Reg. No. 20 | 12 0489 |
|---|----------------|---|--|
| Physici edical Exami | | | 3. Time of Death 1750 hrs |
| | | 4a. Facility Name (if not institution, give street and number) 49 Wise Avenue 4b. City, Town, or Location of Death Dundalk 4c. County of D Baltimore C | |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Add 19 | Birthplace (State or preign Country) NJ |
| id bow any | _ | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore Dundalk | 10d. Inside City Limits 1 Yes 2 No |
| with the Maryland ms 23a or 28a-f show be notified at once. | Director | 10e. Street and Number 10f. Zip Code 10g. Citizen of What 0 | Country? |
| death with the rest tems 23a must be noti | Funeral [| 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A White, etc. | |
| 0036 whim 72 hours after death with the Maryland giene. ter than "natural", or items 23a or 28a-f ahe her than "natural", or items 25a or 28a-f ahe Medical Examiner must be notified at once | þ | Widowed 4 Divorced in res, Give had of pates: 1 Yes 27 No specify: Specify: 15 Decedants Education (Specify sorth pichort grade completed). 150 Decedants Have Convention (Give kind of work done | ess/Industry |
| ₹ 8 ₹ 8 ₹ 1 | Completed | | ive |
| 2 2 2 3 | To Be | | |
| Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If item 27 is n injury or other traumatic | | 4 Dollation 5 Other opecity. | lle, MD |
| Balt permit. Depart Import | | 21 Signature of Funeral Service Lioens MOU 22. Name and Address of Facility CAFA/Stephen D. Lo 8717 Green Pastures Dr. Balto 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart | hrmann P.A. MD, 2128 |
| Physician /Medical £xaminer | | Table Part I. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): | Between Onset and Death |
| | miner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | |
| cecuted s and - transit | Exa | events resulting in death) Last Due to (or as a consequence of): | |
| O, e be e: /siciar burial | ledical | | Verv |
| Box 6876(death certificate he attending physical for use as the b | Physician/M | If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify) 9 Unknown | Day Year |
| P.O. Es that the igned by the detached | Š | 1 Yes 2 No 3 | |
| of Vital Records, P.O. Esp Physician: The law requires that the After this certificate has been signed by the neral director, page 2 should be detached. | Completed | 24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ | |
| /ital Rec | å | 25. Was case referred to medical examiner? Hospital: | ther Scane |
| ion of Vitending Physicath. or: After this the funeral dir | ion: To | 1 V Yes 2 No 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred | nally |
| ViSi or At fier d in by | Certification: | 2 Accident Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Town, State) 4 Homicide 4 Homicide Residence 28f. Location (Street and Number of Town, State) 49 Wise Dundalk, MD. | Rural Route Number, City |
| Di To the Hospital of within 24 hours at To the Funeral I completely filled | Medical (| | stated. o the cause(s) |
| | ¥ | 29b. Signature and title of certifier 29c. License number 29d. Date signed of February 8, 20 | |
| Prent | | 30. Name an factors of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | |
| Si Regis | tate | ate 31. Date filed (Month, Day, Year) 32. Registrar's Signature | |

12-01344 Thomas Skelding

P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| omas Skelding | | State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 2 1 8 9 | | | | | | | | | | | | | |
|--|--------------|--|---|--------------------------------------|----------------|--------------------------------------|------------------|--|-------------------------------------|--------------------------------------|----------------|--------------|---------------------|--------------|----------------------|
| Physician | | 1. Decedent's Name (First, Mide | gistrar Decedent's Name (First, Middle,Last) | | | | | | | | | Year | 3 | Time of | 1 |
| al Exam | nine | Thomas G Skelding February 14, 2012 | | | | | | | | | | | | nrs | |
| | | 4a. Facility Name (if not instituti | | 4b. City, Town, or Location of Death | | | | 4c. County of Death Baltimore County | | | | | | | |
| | | 302 E. Joppa Road A | pt. 1908 | | | Towson | | | | | | | | | |
| Funera | al | 5. Social Security Number | 6. Sex | 7. Age (In yrs. las | st birthday) | If Under 1 | | If Under 2 | 4Hrs. 8 | 3. Date of Bi | | i i | 9. Birth Foreign | place (Sta | te or |
| Directo | r | 168-52-5674 | 1 M 2 F | 46 Yrs. | | Days | Days Hours Mir | | 10-0 | 09-1965 | | Cour | Country) HI | | |
| | 1 | Usual Residence of Decedent | | | | | | | | | | | | | |
| any | 1 | 10a. State 10b. County 10c. City, Town or Location 10d. Ins | | | | | | | | | | | City Limits | | |
| E | یا او | MD Balt | imore | 302 | E Jop | pa Ro | d A | pt 1 | 908 | Tows | son | MD | | 1 XYes | 2 No |
| Aaryland 28a-f show | | 10e. Street and Number | 10e. Street and Number | | | | 10f. Zip Code | | | | | zen of Wha | t Count | ry? | |
| e Ma | Director | 302 E Joppa | Pd Ant | 1908 | | 212 | 86 | | | | US | SA | | | |
| 11215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene. Acade other than "natural", or items 23a or 28a-f shown the Modified Preminer must be notified at once | | | | cedent Ever in U.S | s. 13. Wa | s Decedent | | anic Origin? | (Spec | ify Yes or N | 0- | 14. Race - | | an Indian, | Black, |
| ath w | Fineral | 1 X Never Married 2 1 | Married Armed F | Forces? If Y | | es, specify Cuban, Mexican, Puerto R | | | | can, etc.) | White, | White, etc. | | | |
| er de | | I 3 I Widowed 4 I U | 1 Yes 3 Widowed 4 Divorced If Yes, Give Year | | | Yes 2 No specify: | | | | | Specify: Cauc. | | | | |
| rs aft | Completed by | 15. Decedent's Education (Sp | 6a. Decedent's Usual Occupation (Give kind of w | | | | | work done 16b. Kind of Business/Industry | | | | | | | |
| hou that | 1 2 | Elementary/Secondary (0-12 | | 1-4 or 5+) | during m | ost of workin | ng life. [| OO NOT use | e retired | 1) | | | | | |
| 36 mm 72 | | | 5 | | Libra | arian | | | | | Ur | niver | rsi | ty | |
| Series Siene | | 17. Father's Name (First, Middl | | | | | 18 | 3.Mother's N | Name (F | irst, Middle, | | | | | |
| 21215-0036 ould be filed within 7 Mental Hygiene. marked other than | ent, th | 1 - | | | | | | Jud | ith Elsasser | | | | | | |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Tis marked other than "matural", or items 23a or 28a-f she in marked the Nacial Name of the marked other at an arms. | | Gally 11. Dicellaria | | | | | | | | | , State, | Zip Code) | | | |
| MD d 2 sho lth and n 27 is | | Gary M. Ske | lding/fa | ather | 125 | St J | ame | s St | Μā | nsfi | eld | PA I | 169 | 33 | |
| ल ल ह | T a | 20a. Method of Disposition | <u> </u> | 20b. P | lace of Dispos | ition (Name | | | | Date | 20c. | Location - (| City or T | own, Stat | • |
| of H | | 1 Burial 2 X Cremati | | | rematory or ot | | m = + | -0.51 | 2_1 | 6-12 | TAT | illia | ams | nort | PA |
| Pag. Pag. | ŝ | 4 Donation 5 Other | Specify: | | ldwood | J Cre | dross (| of Eacility | 2-1 | .0-12 | | | | | |
| Baltimore, permit. Pages 1 ar Department of He Important: If ite | 5 | 21. Signature of Funeral Service | e Licensee | MO15-85 | - 22.1 | valle and Ad | 1 01033 (| n Da | AFA | /Ster | oher. | Balt | ohi | rmanı MD | 21286° |
| | | 23a. Part I. Enter the disease, | VI () I XXXA-A | | | | | | | | | | | | nate Interval |
| Physicia /Medica | _ | failure. List only one caus | e on each line. | | | | | | | , | | | | | n Onset and Death |
| Examine | | Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease | | | | | | | | | | | | | |
| | | or condition resulting in death) | | a consequence of |): | | | | | | | | | | |
| | П, | Sequentially list conditions, if any, leading to immediate | b Due to (or as | a consequence of |): | | | | | | | | | | |
| | | cause, Enter Underlying Cause | | | | | | | | | | | | | |
| | اير | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | | | |
| executed an and | transit | dd | | | | | | | | | _ | | | | |
| ian ex | la l | UNPENDED | AMENDED | | | | | | | | | | | | |
| OX 68760, eath certificate be attending physic | e par | IF FEMALE: | | , outcome of pregr | nancy | | | | | | 23 | d. Date of | | | V |
| Box 68760 death certificate be attending physi | as th | 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy | | | | | | | | | İ | Month | D | ay | Year |
| or the ce | or use | past 12 months: 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown | | | | | | | | | | | | | |
| Ihe g | g . | Part II. Other significant con | 3 OIIIK | | eulting in the | underlying c | ause ni | iven in Part | | 23e. Did | tobacco | use contrib | bute to | he cause | of death? |
| P.O. | | | | to death but not re | ssumg in the | andonymig o | auco g. | | | 1 □ Y | es 2 | No 3 | Prob | abiy 4 | Unknown |
| B, P.C ires that | d be | Obesity, Sleep Apr | ea | | | | | | | 24a. Wa | | SELECT AND | -1 | | ngs available |
| rds requi | should | to au | | | | | | | | opsy prior to completion of cause of | | | | | |
| Records, The law requir | ge 7 | | · | | | | | | | | formed? | | Ye | s 2 | 2 No |
| tal Rections The | | | cal | | | 26 | S.Place | of Death (C | heck or | nly one) | | | | | |
| iciar s cer | | examiner? | Hospital: 1 | Inpatient 2 | ER/Outpatien | t 3 DO | A | Other ₄ I | Nursing | Home 5 | Resid | ence 6 🗸 | Other | : Scene | |
| of Vitaling Physician | E | 27 Manner of Death | 28b. Time of | Time of Injury 28c. Injury at Work? | | | | 28d. Describe how injury occurred | | | | | | | |
| ading th. | e fun | 1 V Natural 5 P | ending (Mor | nth, Day,Year) | | | 1 Y | 'es 2 🔲 N | 10 | | | | | | |
| SiG Atter | by the | 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of | | | | | | | | | | er of Ru | ral Route | Number, City | |
| Division tal or Attendius after death. | filled in by | EI = outside = de | ould not be etermined (Specif | | | | | | | or Town | , State) | | | | |
| ospit hour | | | 4 Homicide | | | | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physis | completely | 29b. Signature and title of certifier 29c. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and miner as stated. 29c. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause occurred at the time, date and place, and due to the cause occurred at the time, date and place, and | | | | | | | | | | e cause(s |) | | |
| To To | com | 29b. Signature and title of cer | | 29c. License number | | | | | 29d. Date signed (Month, Day, Year) | | | | | | |
| | | Los. Signaturo aria tito or cor | v. V | | | | O.C.I | M.E. | | | Fe | bruary 1 | 5, 201 | 12 | |
| - | | | | | | | | | | | | | | | |
| D | I | 30. Name and address of per | son who completed ca stant Medical Ex | ause of death (Item | 123a) | ore Street | Rall | imore M | D 212 | 223 | | | | | |
| | | Ling Li, MD Assis | Local Control of the | | | ne olieet | , Dail | iniole, M | - 414 | | | | | | |
| | | 31. Date filed (Month, Day, Ye | | Registrar's Signati | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MARY SCOTT J. 2012 02 16 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TURNER STATION 127 OAK STREET If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 🗆 M 2 🔀 12/09/1926 ĎC 577-40-5668 85 lna. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **X**□ Yes 2 □ No MD BALTIMORE TURNER STATION 10e. Street and Number 10g, Citizen of What Country? 127 OAK STREET 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify. Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4YRS NURSE HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **JEFFERSON JOHNSON** EDITH JENKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA BRANCH/NIECE 2901 NOVEMBER, BOWIE, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HARMONY MEM PARK 02/22/12 HYATTSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC BALTIMORE, MD 21217 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of MYOCARDI if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of CONGESTIVE resulting in death) Last Due to (or as a consequence of

Physician/ Medical Examiner

Physician/

-Medical

Examiner

Funeral

Director

items 23a or 28a-f show her must be notified at

ed other than "natural", or iter event, the Medical Examiner

other traumatic

injury or Department of Important: If any injury or

If item 27

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Je filed with: *al Hygiene. *ar than "r

Should be filed with and Mental Hygien is marked other the

Director

Funeral

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Completed

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death v

72 hours after

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Exami

dedical

To the Hospital or Attending Physician: funeral s after death.

Director: Af
d in by the fu

29b. Signatura

and title of certifier

H. ODUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

| Physician/ | 16 FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 100 9 Unknown | 23c. If yes, outcome of pregnancy 1 | 23d. Date of delivery Month Day Year |
|--------------|---|---|---|
| by | Part II. Other significant conditions of | ontributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| Completed | DE Was and referred to modical | | 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No |
| Be | 25. Was case referred to medical examiner? | 26. Place of Death (Check | (only one) |
| 2 | 1 Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho | me 5 Residence 6 Other (Specify) |
| Certificate: | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b | (Month, Day, Year) Injury work? M 1 □ Yes 2 □ No | 28d. Describe how injury occurred |
| | 4 Homicide determined | e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| edical | 29a. Certifier 1 Certifying Phys (Check 2 Medical Exami | sician: To the best of my knowledge, death occurred at the time, date and place, ar iner: On the basis of examination and/or investigation, in my opinion, death occurred at | nd due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s) and manner stated. |

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

035306

Ro Scute 200

29d. Date signed (Month, Day, Year)

State Registrar PHILADERSHIA

| | | | State | oartment of Health and Nertificate of Death | | 2012 | 01.000 |
|--------------------------------|---|---|--|---|-------------------------------------|---------------------------------------|--|
| | | | Decedent's Name (First, Middle, Last) | or mode or bearing | 2. Date of Death | J. No. 4. U I 4. | 3. Time of Death |
| | Physicia Medi | | Ralph "C" Stone | | Month February | Day Year | 2:45 P ^M |
| | Exami | | 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | 11 CDI dai y | 4c. County of Death | L 2:45 P |
| | <i>!</i> | | Holy Cross Hospital | Silver Spring | | Montgome | rv. |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, | Months Days Hours Min. | 8. Date of Birth (Month, Day, Ye | 9. Birtho | lace (State or Foreign |
| | | 1 | 551-16-6354 1 ★ M 2 □ F 91 Yrs. | | June 17, | | fornia |
| | land shov | ţ | 10a. State 10b. County 10c. City, Town or L | ocation | | 11 | Od. Inside City Limits |
| | Mary 28a-1 otifie | irec | MD Prince George's Laurel | | | | 1 ☐ Yes 2XXXNo |
| | th the | Funeral Director | 10e, Street and Number | 10f. Zip Code | 10g | g. Citizen of What Coun | try? |
| | ms 2. | ner | 9000 Briarcroft Lane, Apt. 231 | 20708 | | USA | |
| ' 0 | or ite | by F. | | . Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - America Black, White, e | |
| 036 | 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at | | | 1 ☐ Yes 2 🔀 No Specify: | | Specify: Whit | |
| 5-0 | hour "natu | Completed | 15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give | edent's Usual Occupation | 16 | b. Kind of Business/Ind | ustrv |
| 2 | within 72 giene. ner than t, the Me | E | Elementary/Secondary (0-12) College (1-4 or 5+) | e kind of work done during most of worki DO NOT use retired) | ng | | , |
| 2 | d wit Hygie ther nt, th | Be C | 12th 1 St 17. Father's Name (First, Middle, Last) | <u>eamfitter</u> | | Constructi | on |
| ano | be file antal ł ked o c eve | 10 | | | e (First, Middle, Maid | den Surname) | |
| ary | nd Me | | | Inez Ho | - | | - |
| Š | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | | Garold Raymond Stone/Son 9202 | ling Address (Street and Number or Rura Place, | | | ode) |
| ore, | of He fiter | | 20a. Method of Disposition 20b. Place of Disp | osition (Name of | | MD 20708 c. Location - City or Tov | vn, State |
| <u>Ĕ</u> | Page ment tant: I | | | ematory or other place) undel Crem. 2/21/ | 2012 | Odenton, MD | |
| Baltimore, Maryland 21215-0036 | permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 | | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility Don | aldson Fu | uneral Home | , P.A. |
| | 002 60 | | MULLET 200 (M01103 | 313 Talbott Avenue | Laure | L, MD 207 | 07 |
| | | | 23a. Part 1/ Enter the disease, or complications that caused the death. Do not en shock, of heart failure. List only one cause on each line. Immediate Cause (Final | | r respiratory arrest, | | Approximate Interval Between |
| ···~. | Ph_sician/ Medical | | disease or condition resulting in death) a. Alzheimer | 's Dementia | | 2 | Onset and Death -3 yrs |
| | Examiner | | Due to (or as a consequence of); | l Vascular Disease | | | ss than |
| | | ner | if any, leading to immediate Due to (or as a consequence of : | r vascular Disease | | | yrs ess than |
| | uted nd ransit | Examine | Cause (Disease or injury that initiated events c Diabetes | | | | years |
| | ate be executed physician and the burial-transit | al E | resulting in death) Last Due to (or as a consequence of): | | | | |
| 09/ | certificate be executed nding physician and use as the burial-transi | edical | d | | | | |
| 89 | ertific ding a | ŽΨ | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | | | T | |
| BOX | requires that the death certifica been signed by the attending pl should be detached for use as t | Physician/Me | in the past 12 months? | ☐ Ectopic pregnancy ☐ Other (specify) | | 23d. Date of deliver | y Day Year |
| E | the de | hysi | g Unknown | | | | |
| J. | that med b | by P | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I. | 23e. Did tobaco | co use contribute to the | cause of death? |
| ďS, | quires en siç ould b | | Recurrent urinary infection | | 1 🗆 Yes | 2 No 3 Proba | bly 4XXUnknown |
| Records, | law re las be | Completed | | | 24a. Was an autopsy | 24b. Were autops | y findings available pletion of cause of |
| Y E | cate h | S | | | performed | ? death? | |
| Vita | certifi rector | m | 25. Was case referred to medical examiner? | 26. Place of Death (Check | only one) | | |
| 01 < | Phys | <u>۵</u> | 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpatiel 27. Manner of Death 28a. Date of injury 28b. Time of | | | 6 Other (Specify) | |
| ב ב | ding th. : After e fune | Certificate: | 1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation | f 28c. Injury at work? M 1 □ Yes 2 □ No | 8d. Describe how in | jury occurred | |
| NISION | Atter | ij <u> </u> | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str | | 8f. Location (Street | and Number or Rural R | oute Number |
| ≧ : | tal or rs after al Dir led in | ္ရွိ [| building, etc. (Specify) | | City or Town, Sta | | oute Nambol, |
| | on the bookpara or Attending Physician: The law requires that the death, with 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for the funeral director. | Medical | 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or invest | itigation in my opinion, death occurred at t | he time data and pla | on and due to the equa | 10 L - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - |
| | thin 2 the 1 omple | | only one) 3 - Certifying Nurse Practitioner: To the best of my knowledge | , death occurred at the time, date and place | e, and due to the cau | use(s) and manner as sta | ted. |
| | - ≥ - 5 | | 29b. Signature and title of certifier | 29c. License number | | Date signed (Month, Da | |
| | | - | 30. Name and address of person who completed cause of death (Item 23a) (Type, F | D35996 | F | ebruary 20 | , 2012 |
| | | | Linda M Burnell MD 2720 Unit | versity BLVD, #400 | Tuth a a + - | ~ MD 000 | |
| | State | 9 | 31. Date filed (Month, Day, Year) 32. Regist ar's Signature | | , Wheato | n, MD 2090 | 14 |
| | Registra | r | FED & I CUIL Cenum B. | parle | | | |
| 1 18 4 | H 17 Day 06 20 | | | | | | |

amend 5, per fh. g924 2-29-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | State of Maryland / De | epartmer Certificate | | | | 21 | 112 | 01.899 |
|---------------------|--|-------------------------------|---|----------------------------------|------------------------------|------------------------------------|------------------------------------|--------------------------------------|-----------------------------------|-------------------------------------|
| | | - | Decedent's Name (First, Middle, Last) | | OI DE | airi | 2. Date of De | Reg. No. 🛴 🛚 ath | 116 | 3. Time of Death |
| | Physicia Medic | | Herman R. Szyma | ınski | | | Month Feb. | | 1 ^{Year} | 12:30 PM |
| | Examin | | 4a. Facility Name (if not institution, give street and number) 254 Foster Knoll Drive | | Town, or Lo Joppa | cation of Death | | 4c. County Hari | of Death | Co. |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd: 215 28 0296 1 ☑ M 2 ☐ F 80 Yrs | Months | | Under 24 Hrs. lours Min. | 8. Date of Bir Month, Da Aug | th 20°,1931 | 9. Birthp Count Mary | lace (State or Foreign Land |
| | D OW | L | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o | | | | | | 1. | |
| | arylan a-fsh fied a | scto | MD Baltimore | Location | Dı | ındalk | | | - [' | 0d. Inside City Limits 1 ☐ Yes 2 No |
| | or 28 e noti | ä | 10e. Street and Number | 10f. Zip | Code | | | 10g. Citizen of | What Coun | |
| | s 23a | era | 7520 Old Battle Grove Road | | 21222 | 2 | | United | Stat | es |
| | death item ner m | Fur | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? | 3. Was Deced | ent of Hispa ify Cuban, N | nic Origin? (Sp Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Rad | ce - America | |
| 5 | al", o | Completed by Funeral Director | 1 Never Married 2 Married 1 Yes 2 No 3 Wildowed 4 Divorced Year or Dates. | 1 🗆 Yes | 2 🖾 No S | Specify: | | - 1 | Whit | |
| Š | hours natur Jical B | olete | 15. Decedent's Education 16a. De | cedent's Usua | | | | 16b. Kind of B | | |
| 7 | nin 72 ne. .han " | ошь | Elementary/Seconday (0-12) College (1-4 or 5+) | ive king of woi e. DO NOT use | k done durir retired) | ng most of work | ing | | | ing Insp. |
| 7 | filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho dother the Medical Examiner must be notified at event, the Medical Examiner | BeC | 6 Years Bu 17. Father's Name (First, Middle, Last) | <u>ilding</u> | | | - /Fired Adjudget | Baltim Maiden Surnam | | ity |
| an | ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke other than "natural" or items 25a or or 28a-f show marke event, the Medical Examiner must be notified at | 인 | Bernard Szymanski | | '° | | aret Tay | | e) | |
| Maryland 21215-0036 | should and Ma is mar raumati | | | ailing Address | (Street and | | | r, City or Town, S | State, Zip C | ode) |
| | 1 and 2 should be of Health and Ment if item 27 is marked other traumatic e | | | | | oll Driv | re Jopp | oa, Mary | land | 21085 |
| Baltimore, | Page 1 a ment of H ant: If ite ury or otl | | | crematory or o | her place) | ŧ | Date | 20c. Location | • | |
| | permit. Page Department of Important: If any injury or once. | | | | | | | 2 Dunda | | |
| n | permit. Departr Importa any inji | | Frence E Ken | | | | | Dundalk Marvland | | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart tallure. List only one cause on each line. | | | | | | | Approximate Interval Between |
| - 1 | hysician | 60 6 | Immediate Cause (Final disease or condition Cardiomyonathy | Ischem | ic | | | | | Onset and Death Years |
| | Medical Examiner | | Due to (or as a consequence of): | | | | | | | |
| | | ner | Sequentially list conditions, if any leading to in mediate | Disea | se | | | | | 30 Years |
| 1 | uted Id ansit | Examiner | cause. Enter Underlying Cause (Disease or linjury that initiated events c. | | | | | | | |
| Ď, | e exec cian ar urial-tı | al E | resulting in death) Last Due to (or as a consequence of): | | | | | | | |
| 9 | cate by physic the b | edical | d | | | | | | \perp | |
| 000 | certification of the second of | Physician/Me | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | o [[=i- | | | | 23d. Da | te of delive | ry |
| POX | death ne atte ed for | sicia | 1 Ves 2 No | 3 ☐ Ectopic p 5 ☐ Other (sp | ecify) | | | Mo | onth | Day Year |
| л Э | at the d by the letach | | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the | ne underlyina o | ause given i | in Part I. | 23e Did to | bacco use cont | ribute to the | e cause of death? |
| λ Γ | ires th signe d be c | Completed by | Hypertension, Emphysema | | | | | | | ably 4 🗆 Unknown |
| 0 | v requ | olete | | | | | 24a. Was | an 24b. | Were autop | sy findings available |
| ဗ္ | he lav tre has vage 2 | omi | | | | | autor perfo | rmed? | prior to con death? 1 🔲 Yes | npletion of cause of |
| or vital Records, | cian: ertifica ector, p | | 25. Was case referred to medical examiner? | | 7 | of Death (Chec | | 2.05/10 | | Son's |
| = | Physia this call dire | <u>1</u> | 1 | | Other: 2 Bc. Injury at | 4 Nursing Ho | | lence 6 AOth | er (Specify) | Residence |
| | nding tth. : After e fune | cate | 1 ☐ Natural 5 ☐ Pending (Month, Day, Year) injul | | work? | 2 □ No | 28d. Describe n | ow injury occurr | ea | |
| DIVISION | r Attel ter dea rector | Certificate: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify) | street, factory | office | | 28f. Location (S City or Tow | treet and Numb | er or Rural i | Route Number, |
| 5 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | | 4 | | | d | | | | |
| | Host 24 ho Fune eted fi | Medical | 29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, dear only one) 3 Certifying Nurse Practioner: To the best of my knowledge. | vestigation, in r | ny opinion, d | leath occurred a | t the time, date a | nd place, and du- | e to the cau | se(s) and manner stated. |
| | To the within To the compl | Σ | only one) 3 — Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier | | License nui | | | e cause(s) and ma 29d. Date signe | | |
| | | | I May my | | D18 | 3642 | | Feb. 1 | .6, 20 | 12 |
| | 10 | | 30. Name and address of person who completed cause of death (Item 23a) (Typ | | | | | | | |
| | Q. | | Jeffery M. Pargament, M.D. 9518 E | Phila | delphi | ia Road | Baltin | nore, Ma | rylar | d 21237 |
| | Stat Registra | e | 31. Date filed (Month, Day, Year) 1 2012 32. Fegistrar's Signature | parks | | | | | | |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shirley Stinebaugh 2012 Mae Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Baltimore 9uare 8. Date of Birth (Month, Day, Year) **Funeral** . Age (In yrs. last birthday If Under 24 Hrs. 9. Birthplace (State or Foreign **Director** 212-36-3656 1 ☐ M 2**XX** 71 March 20,1940 Maryland Usual Residence of Deced 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 28a-f Maryland Harford 1 Yes 2X No Joppatowne ò 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Stinebaugh, Shieley 608 U.S.A. Riley Ct., Apt B 21085 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes ZXX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Completed 3XXWidowed 4 ☐ Divorced Year or Dates White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) It of Health and Mental Hygiene.

If item 27 is marked other than '
or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Thomas Hugel Mary DeForge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Phillip Stinebaugh/Son 314 Winterberry Dr., Edgewood MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 19, 2012 MD Atlantic Crematory Feb. Glen Burnie 22. Name and Address of Facility
Schimunek Funeral
Baltimore MD 21 21. Signature of Fune al Service Licens Home, Inc. 23a. Part 1. Enter the disease, or companies, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ause on each line Interval Between Onset and Death Physician/ imonia Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or injury tran that initiated events resulting in death) Last and attending physician a for use as the burlal-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day be detached the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 WUnknown Completed should Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 performed? Yes 2 No death? this certificate 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at I Director: After the din by the funeral Certificate: 28b. Time of 28d. Describe how injury occurred 1 ✓ Natural 2 ☐ Accident 5 Pending 1 🗌 Yes Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of erson who completed cause of eath (Item 23a) (Type, Print) 9000 Franklin Square drive, Baltimore Young 31. Date filed (Month, Day, Year) FEB 2 1 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Co. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth Hours (Month, Day, Year) **Director** 218-12-1677 1 🗆 M 2 🗶 F 87 04/12/1924 Delmar, MD s 23a or 20a., ... nust be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Anne Arundel Co. Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 7101 Bay Front Drive Unit 519 United States ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. , or Completed by 1 Never Married 2 Married Yes Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Teacher Anne Arundel County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Short William Melson Mattie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr once. Mr. Richard V. Singleton II/Son 36 Fair Haven Road, Fair Haven, NJ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place. Glen Haven Mem. Park 02/20/2012 Glen Burnie, Maryland 21. Signature of Funeral Sen 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Onset and Death Immediate Cause (Final Physician/ lele disease or condition resulting in death) Medical Due to or as a consequence of): **Examiner** Kalemia Sequentially list conditions, Due to (o as consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami physician and that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Day 9 Unknown Unknown signed by ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? - Peripheral 1 Yes 2 No 3 Probably 4 Unknown Myel. dysplasia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform ☐ Yes 2 ☐ No 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death,
To the Funeral Director: After this certified 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 1 No 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 96 16 12012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

1058ph

2012

31. Date filed (Month, Day,

Box 68760

P.0.

Division of Vital Records,

116 Detense Huy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary SASSE 9.42 A M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death AGNES MOSPITAL Baltimore Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Days Min 12/26/1916 1 M 2 XX Months Hours 212-07-0206 95 **Director** Yrs PA Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t Funeral 912 S. Rolling Road 21228 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XX No Specify: White Completed 3 XWidowed 4 □ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12Homemaker Own Home is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental ပ Harry Christopher Weigman Alice Marie Lepson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Mrs. Carol Vasquez / Daughter 6506 Dolphin Court Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 2/24/2012 Glen Burnie, MD permit. 21. Signature of Finaral 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MYOCARDIAL INFARCTION DAY Medical resulting in death) Due to (or as a consequence of) Examiner THERO SCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying equentially list conditions, Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NEUMONIA 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? this certificate 2 No 1 Yes To the Hospital or Attending Physician: To within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 🗌 No Accident Investigation Could not be filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit 29d. Date signed (Month, Day, Year) asanthalcuma 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21229 MVASANTUAlcuman 516-N. ROLLING RDAD MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 2012 DONALD PAUL SCHULZ 12:35 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
Feb. 2, 1951 **Funeral** 9. Birthplace (State or Foreign 1**x** M 2 □ F Days Hours Min. Maryland Director 213~54~1589 61 Isual Residence of Decedent 23a or 28a-f show 10a. State Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits MD 1 🗆 Yes 2 🙀 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 56.4 Kirkland Dr. 217_3 USA or items 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Lver Armed Forces? 1 Yes 2 X No 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. ò If Yes, Give Year or Dates 1 Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry h and Mental Hygiene.
7 is marked other than "n traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Graphic Artist Printing it. Page 1 and 2 should be filed w intment of Health and Mental Hygi-ortant: If item 27 is marked other njury or other traumatic event, It Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gilman Evans Schulz Anna Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette Quesenberry (Sister) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 5604 Kirkland Dr., Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore Crematory
@ Loudon Park ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 2/21/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No ၉ Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral (Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number,

State Registrar

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

DHMH 17 Rev 7/2009

within 2

Medical

29a. Certifier (Check

only one

3

29b. Signature and title of certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 04904 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edna Joan Farrell Sangimino February Tb, 2012 11:25 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 052-28-5996 Hours Country) **Director** 1 🗆 M 2 😿 F 78 March 21, 1933 New York Usual Residence of Decedent 28a-f show 10a. State "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11205 Old Club Road 20852 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John L. Farrell Edna G. Ziegler traumatic t. Page 1 and 2 should b tment of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark J. Sangimino / Son 714 Winter Pine Drive, Mars, Pennsylvania 16046 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State February Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 20, 2012 Silver Spring, Maryland Signature of Funeral rvice Licensee Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Intracerebral Hemorrhage Non Traumatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate Examine Due to (5) as it nonsequence of cause. Enter Underlying burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown g 🗌 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 \square Yes 2 X No 3 \square Probably 4 \square Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 X No Il or Attending Physician: The safter death. Director: After this certificate ! 2 🗌 No 1 Yes funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 X No Inpatient 2 K ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide

P.O. Records, ngimino, Hospital

Box

Baltimore, Maryland 21215-0036

within 24 hours a

Registrar

State

4 Homicide

29b. Signature and tit

29a, Certifier (Check

Alan R. Sheff, MD

determined

29c. License number D36797

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year, February 16, 2012

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10215 Fernwood Road, Bethesda, Maryland 20817

31. Date filed (Month, Day, Year) FEB 2 1 2012

3

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Facility Name (not institution Examiner give street and number 4b. City, Town, or Location of Death 4c. County of Death **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country)
Pepal 1 🗆 M 2 🔀 F ^{(M}07/01/1979 Director 213-85-2634 32 28a-f show 10a State with the Maryland Director 10h County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No MD Baltimore ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important if item 27 is marked other there any injury or other traumation. items 23a 4411 LaPlata Ave, Apt. C 21211 Nepal 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2X Married Black, White, etc. 1 Yes If Yes, Give 2**X** No 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify. Year or Dates Asian 15, Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Laxman Lal Shrestha Laxmi Shrestha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kishor Chandra Shrestha / Husband 4411 LaPlata Ave, Apt. C, Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Atlantic Crematory 2/19/2012 Glen Burnie, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day signed by the at id be detached fo Pregnant at time of death Month 2 No Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, Completed 2 No 3 Probably 4 Unknown should 1 🗌 Yes peen 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death?

1 Yes 2 No autopsy perform Director: After this certificate Yes 2 XNo or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital မ Other: 2 ER/Outpatient 1 Inpatient Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural (Month, Day, Year) 5 Pending hours after death. the Accident Investigation М 1 🗌 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined building, etc. (Specify) To the Hospital within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Pay, Year) 01 address of person who 10 V Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical February 2012 BERNARD 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Sinai Hospital of Baltimore Baltimore 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Fer-nard Smit **Funeral** Director 218-22-7322 1 X M 2 🗆 F 85 MD 5/22/1926 Usual Residence of Decedent 10d. Inside City Limits 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State death with the Maryland other traumatic event, the Medical Examiner must be notified at Director BALTIMORE 1 X Yes 2 No MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21209 1878 AUTUMN FROST LANE or items 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify. If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) ELECTRONICS BUSINESS OWNER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ MICHELSON MARY SMITH JULIUS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1878 AUTUMN FROST LANE; BALTIMORE, MD 21209 EVELYN SMITH / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/19/2012 BALTIMORE, MD ☐ Donation 5 ☐ Other (Specify) MOSES MONTEFIORE of Funeral Service Lightsee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 23a. Part 1. Enter the disease, or compiler tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Exami Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the ding p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Month in the past 12 months?
1 ☐ Yes 2 ☐ No lor 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the pause of death? Completed by fibrillation, single vesse pertension, atrial 1 🗌 Yes 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pass grafting Was an autopsy performed page 2 1 Tes certificate 26. Place of Death (Check only one) 25. Was case referred to redical funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner' Hospital: 1 1 1 Tyes No ER/Outpatient 3 DOA မ Inpatient 2 after death.

Director: After this 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Mann Death Certificate: work' To the Hospital or Attending Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a
To the Funeral C
completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number etruan 17,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIU Kinistine T. YVWUL MD SIVOI Haspital of Baltimore State Registrar

Jerry Stewart 12-01136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| JN K UN K | | State of Maryland | d / Department Certificate | | and I | Vlental | | 20 | 12 01.00 | | |
|---|--|--|--|--------------------------------------|----------------------|---------------------|--|---------------------------------|---|--|--|
| Physicia | | Registrar 1. Decedent's Name (First, Middle,Last) | Continuate | Or Dodin | | - | 2. Date of Dea | teg. No. | 3. Time of Death | | |
| Medical Exami | | Jerry Bernard Stewart | _ | | | | Month February | Day Year 7, 2012 | 2000 hrs | | |
| | | 4a. Facility Name (if not institution, give street and number | | 4b. City, Tov | | ation of De | | 4c. County of | Death | | |
| ÷ | | 609 East Biddle Street | | Baltimo | | | | N/A | | | |
| Funeral Director | | | Age (In yrs. last birthday) | If Under | | Hours N | Ain. | | Birthplace (State or Foreign | | |
| Director | | 217-64-5129 1XM 2 F | 53 | rs. | | | 04/01 | /1958 | Country) MD | | |
| any | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or Loc | ation | | | | | 10d. Inside City Limits | | |
| . . | _ | MD N/A | Ba | ltimo | re | | | | 1 X Yes 2 No | | |
| Aaryland 28a-f show 1 at once. | Director | 10e. Street and Number | <u> </u> | 10f. Zip Co | | | T | l0g. Citizen of Wha | t Country? | | |
| death with the Maryland or items 23a or 28a-f sho must be notified at once | 1 | 4845 Reisterstown Rd. | | 212 | 215 | | | U.S | .A. | | |
| h with | Funeral | 11. Marital Status 1 Never Married 2 Married Armed Force | | | | | Specify Yes or No erto Rican, etc.) | - 14. Race - White, | American Indian, Black, etc. | | |
| er deal | ᆲ | 1 Yes Widowed 4 Divorced If Yes, Give Year | 2 X No | Yes 2 | l No. o | nooih: | | Specify: B | l a ala | | |
| hours after natural", Examiner | þ | 15. Decedent's Education (Specify only highest grade co | | ent's Usual Oc | | | of work done | 16b. Kind of Busin | | | |
| 2 2 | 9 | Elementary/Secondary (0-12) College (1-4 o | during | most of working | ng life. DC | NOT use | retired) | Depart | ment of | | |
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| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than | | | | | | | | | | | |
| 121 Id be 1 Aental | | | | | | | | | | | |
| E La sh O | 195. Maining Address (Silver and North Name Relationship (Type, Frink) 186. Maining Address (Silver and North North Name Relationship) 186. Maining Address (Silver and North Nort | | | | | | | | | | |
| e, M I and 2 Health item 2 | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Tow | | | | | | | | | | |
| ا و 🖴 به س | | Burial 2 Cremation 3 Removal from 9 | on-site | | tor | v 0: | 2/19/12 | Baltin | more, MD | | |
| Baltimo permit. Page: Department of Important: | - 1 | 4 Donation 5 Other Specify: 21. Scinature of Funeral Service Licensee | | | | | | | Home PA | | |
| E F P E | - 24 | CX N 100 | 2 | 140 N. | _Fu | lton | Ave., | Baltimo | re, MD21217 | | |
| Physician | \neg | 23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line. Hypex | ed the death. Do not enter ctensive Car | the mode of diovas | lying succe cular | h as cardia Dise | c or respiratory and ease comp | est, shock, or heart licated | Approximate Interval Between Onset and | | |
| /Medical بيّرxaminer | - 1 | | ntal Hypoth | ermia | | | | | Death | | |
| ~.6* | | b. | sequence of): | | | | | | | | |
| | 盲 | Sequentially list conditions, if any, leading to immediate Due to (or as a con | sequence of): | | | | | | | | |
| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a con | sequence of): | | | | | | | | |
| executed an and al - transit | | d. | | | | | | | | | |
| e e e | dical | X UNPENDED AMENDED 23 | a,27,28a-f, | per me, | g925 | 3-7- | 12 sm | | | | |
| Ox 68760 Eath certificate by attending physicoruse as the buse of | /Me | not tall the first service and firstless | ome of pregnancy | | | | oute. | 23d. Date of de | | | |
| certif | cian | past 12 months? | at time of death | Fetal death Other <i>(Specify</i> | | ctopic preg | gnancy | Month | Day Year | | |
| Box 68760 e death certificate b the attending physied for use as the bu | Physician/Me | 1 Yes 2 No 9 Unknown 9 Unknown | <u>. </u> | Jillel (Opecin) | | | | | | | |
| P.O. Is that the gned by the e detache | | Part II. Other significant conditions contributing to dea | ath but not resulting in the | underlying ca | use giver | in Part I. | | | ite to the cause of death? | | |
| ires that the signed by de detach | d by | | | - | | | - | | Probably 4 🗹 Unknown | | |
| cords, law requi | Bet | | | | | | 24a. Was autop | sy pric | ere autopsy findings available or to completion of cause of | | |
| Reco | Completed | | | | | | 1 ✓ Yes | | ath? ✓ Yes 2 No | | |
| Division of Vital Records, P.O. Box 68760 tal or Attending Physician: The law requires that the death certificate by sher death. **In Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director. | Be | 25. Was case referred to medical examiner? | | | | | ck only one) | | | | |
| i of Viding Physic After this (funeral dire | اع | 1 Yes 2 No Inpat 27. Manner of Death 28a. Date of In | ient 2 ER/Outpatie | | Injury at | | | Residence 6 | Subject was | | |
| nding Ph th. :: After 1 | Ë | 1 Natural 5 Pending (Month, Day | (Year) | - 1 | | 2 No | exposed | to cold | environmental | | |
| r Atter | ertification: | 2 X Accident Investigation 5 Suicide 6 Could not be 28e. Place of | -12 fd 8:0 Injury - At home, farm, str | | fice buildi | ng, etc. | 28f, Location (| Street and Number | or Rural Route Number, City | | |
| Div | erti | | ound:In vac | ant ho | use | | Baltimo | re,MD. | Biddle St. | | |
| Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | 20 | 29a. Certifier 1 Certifying Physician: To the best of | my knowledge, death occ | urred at the tin | ne, date a | nd place, a | nd due to the caus | se(s) and manner as | s stated. | | |
| To the within To the compl- | Medical | one) 2 Medical Examiner: On the basis of ex and manner stated | amination and/or investig | | | | d at the time, date | | | | |
| | Σ | 29b. Signature and title of certifier | | | icense nu | | | | (Month, Day, Year) | | |
| | | Couleny_ | | |).C.M.E | • • | | February 8, 2 | -012 | | |
| / | | Name and address of person who completed cause of Laron Locke MD. Assistant Medical Ex | | Baltimore S | treet. B | altimore | , MD 21223 | | | | |
| St. | ate | | ar's Signature | | , - | | | | | | |
| | Registrar FER 2 1 20112 A. A. A. A. A. A. A. A. A. A. A. A. A. | | | | | | | | | | |
| DHMH 17 Rev 1/20 | DHMH 17 Rev 1/2001 ORIGINAL | | | | | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 February 12:05A M Katherine Ann Stump Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oak Crest Care Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕏 F (Month, Day, Year US 09, 1 217-03-9624 93 Mary land Director Yrs 918 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits **Funeral Director** Baltimore Baltimore MD. 1 🗌 Yes 2 🔀 No ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21234 8832 Walther Blvd. USA "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 **X** No If Yes, Give 1 Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: Completed White Year or Dates er than "natur the Medical B 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Norman Nancy Croghan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ś 21078 Andrew G. Stump/ Son 326 Seattle Slew Place Havre de Grace, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Important: If any injury or once, Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Pk! 2-20-12 21. Signature of Juneral Se 22. Name and Ruck Towson Funeral Home, vice Licer 1050 York Rd. Towson, md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ STage Emd Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): led by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ASCVD 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

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Baltimore,

Division of Vital Records, P.O. Box 68760

R067343

Blw. PARKville, MD. 21234

alue M. Brazier, cent

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alice BRAZIER

| lichael Truluck | 1- For State Registrar Certificate of Death Reg. No. 2012 049 | | | | | | | | | | | |
|--|---|--|--|---|-------------------|-----------------------------------|---------------------------|--|---|---|--|--|
| Physicia fedical Exami | | | | uck | | | | 2. Date of Dea Month February | | 3. Time of Death 1900 hrs | | |
| | | Michael Tho 4a. Facility Name (if not institution Franklin Square Hosp | | nber) | 1 | tb. City, Town, or L Baltimore | ocation of Dear | th | 4c. County of Deat Baltimore Co | | | |
| Funeral Director | | 5. Social Security Number 218–51–7033 | 6. Sex 1XXM 2 F | 7. Age (In yrs. 1 | | If Under 1 Year Months Days | If Under 24Hi Hours Mi | | 03,1998 Co | | | |
| | | Usual Residence of Decedent | 1 <u>XX</u> M 2F | | Yrs. | | | PALCI | W,150 0 | | | |
| d any | | 10a. State 10b. County Maryland Balt: | imore | 1 1 | Town or Locati | on | | | | 10d. Inside City Limits 1 Yes 2 XXNo | | |
| Maryland 28a-f show d at once. | Director | 10e. Street and Number 2703 Linwood | | | | 10f. Zip Code 21234 | | 1 | 10g. Citizen of What Cou | • | | |
| death with the Maryland or Items 23a or 28a-f sho must be notified at once | | 11. Marital Status | 12. Was Dece | edent Ever in U | | s Decedent of Hisp | | | United Sta | ican Indian, Black, | | |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tean 27 is marked other than "natural", or Items 23a or 28a-f she transmatic event, the Medical Examiner must be notified at once | Funeral | | arried Armed Fo 1 Yes orced If Yes, Give Year | 2 X No | | es, specify Cuban, Yes 2 X No | | o Rican, etc.) | White, etc. | ite | | |
| ours aft | ed by | 15. Decedent's Education (Spe | or Dates: | | 16a. Deceden | r's Usual Occupation | on (Give kind of | | 16b. Kind of Business | | | |
| 136 hin 72 h e. than "n | Completed | Elementary/Secondary (0-12) | College (1- | 4 or 5+) | , | dent | 50 NOT 436 16 | urea, | Never Wor | ked | | |
| MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica | | 17. Father's Name (First, Middle, | • | | | | | | Maiden Surname) | | | |
| 2121 uld be f Mental markes e event, | To Be | Michael D. Tru 19a. Informant's Name/Relations | | | 19b. Mailing | | | na M. Ke Rural Route Nur | YS mber, City or Town, State | e, Zip Code) | | |
| MD ad 2 sho alth and an 27 is aumati | | Kristina M. K | eys (Mothe | | | | | | le, Marylan | | | |
| nore, MD 21215-0036 sges I and 2 should be filed within 72 hours nt of Health and Mental Hygiene. ft: If item 27 is marked other than "natur other traumatic event, the Medical Exami | | 20a. Method of Disposition 1 X Burial 2 Cremation | _ | m State | crematory or oth | • • | Fel | Date Druary 2012 | Parkville, | · | | |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: Witem 27 is marked other tinjury or other traumatic event, the Med | 4 Donation 5 Other Specify: Parkwood Cemetery 23, 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Crematic | | | | | | | | | _ | | |
| Physician | - | 23a. Part I. Enter the disease, or | complications that ca | used the death | | 8800 Hario | ra Rosa F | arkville. | Maryland 212: | Approximate Interval | | |
| waminer | | failure. List only one cause Immediate Ceuse (Final disease or condition resulting in death) | NA. 142-1- 1-1- | | νn: | | | | | Between Onset and Death | | |
| | | Sequentially list conditions, | b. Due to (or as a | | | | | | | | | |
| | Examiner | if any, leading to immediate cause. Enter Underlying Cause Ulseass or injury that initiated | c. Due to (or as a control of the c | | | | | | | | | |
| cuted and transit | EX3 | events resulting in death) Last | d | consequence o | | | | | | | | |
| be exe | edical | UNPENDED | AMENDED | | | | | | Lood Date of deliver | | | |
| Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | e 1 Live bir | utcome of preg th int at time of de | 2 Fet | al death 3 | Ectopic pregn | ancy | 23d. Date of deliver Month | y Day Year | | |
| Box e death o | hysic | 1 Yes 2 No 9 Unk | nown g Unknow | | eath 5 Oth | ner (Specify) | | | | | | |
| Division of Vital Records, P.O. Box 6876(the Bospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physphelety filled in by the funeral director, page 2 should be detached for use as the b | Ď | Part II. Other significant conditi | ons contributing to | death but not re | esulting in the u | nderlying cause giv | ven in Part I. | | obacco use contribute to s 2 ✓ No 3 ☐ Pro | | | |
| of Vital Records, ag Physician: The law require. The this certificate has been a meral director, page 2 should the | ompleted | | | | | | | 24a. Was autop | osy prior to | topsy findings available completion of cause of | | |
| tal Recol | Com | | | | | | | 1 ✔ Yes | rmed? death? 2 No 1 ✓ Yo | es 2 No | | |
| /ital F /sician: nis certifi director, | e Be | | | | | | | | | | | |
| n of \ding Phy. h. After the funeral | ⊢լ | 27 Manner of Death 28a Date of Jajuny 28h Time of Jajuny 28c Jajuny 24 Work2 28d Describe how injury conjurted | | | | | | | | | | |
| Division tal or Attendit rs after death. Al Director: A | Certification: | 2 Accident Invest 3 Suicide 6 Could | tigation 28e. Place | of Injury - At he | ome, farm, stree | t, factory, office bu | | by another v 28f. Location (S or Town, S | Street and Number or Ru | ıral Route Number, City | | |
| Lospital of thours at hours at the filled | | 29a. Certifier | | | d / Highway | ed at the time date | and place an | 8319 Harford | Road, Parkville, MD se(s) and manner as stat | ed | | |
| Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fi | Medical | (Check only one) 2 ✓ Medical Exam | miner:On the basis of and manner sta | examination a | - | on, in my opinion, | death occurred | | and place, and due to th | e cause(s) | | |
| | Σ | 29b. Signature and title of certifie | - 3 | | | 29c. License O.C.M | | | 29d. Date signed (Mo February 19, 20 | | | |
| | } | 30. Name and address of person | and the second second | | | | | | | | | |
|) | ato | Donna M. Vincenti, MI 31. Date filed (Month - Day, Year) | | edical Exan | Irea · | W. Baltimore S | Street, Baltin | more, MD 21 | 223 | | | |
| Regist | FERULIUM R. K. A. J. | | | | | | | | | | | |

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eugene Anthony Trainor, Jr. February 16,2012 5:05 P. M Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Baltimore County Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days oct. 16, 1928 Hours 215-22-3371 83 1 **X**M 2 □ F Baltimore, MD. Director Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hours" any injury or other terms. 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Baltimore County Sparks Maryland 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21152 United States 14215 Quail Creek Way Unit#208 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Anthony Trainor, Sr. Eva Elizabeth Foster 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21152 Mrs.Bernadette Rose(nee Offutt) Tainor 14215 Quail Creek Way Unit 208 Sparks, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State (Harford County) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Evans Funeral Charel and Cranation Services, Inc. Thesday, Feb. 21, 2012 Forest Hill, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Leffrey L.Cair, Sr. O.S. 22 Name and Address of Facility Less Funeral and Cremation Center, P.A. Lic. #100677

22 Name and Address of Facility Less Funeral and Cremation Center, P.A. 2325 York Road Timonium, Mayland 21093–2215 23a. Part 1 fixer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE RENAL FAILURE PAV Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SPINAL STENOSIS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t ; page 2 s prior to completion death? autopsy performe 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 10 1 Yes 2 \ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

In Funeral Director: Af olderely filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 06-2011

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:50 AM Edward Turner Norman TEBRUMRY 2012 Medical give street and number) 4a. Facility, Name (if not institution, 4b. Pity, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Age (In vrs. last birthday) Birthplac Country) FL Social Security Number Funeral 1 🛛 M 2 🗆 F Months Hours Min. 46 212-80-1415 Director 06/14/1965 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County death with the Maryland Director Examiner must be notified 28a-f 1 🗌 Yes 2 🛣 No Baltimore MD Baltimore o 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a USA 21229 4318 Leeds Ave. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fiber Optic Cable Linesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Christine B. Brant Edward Lee Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4318 Leeds Ave., Baltimore, MD 21229 Christine B. Turner / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD 02/17/12 <u>restlawn M.P.</u> 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hubbard Funeral Home,
Raltimore, MD 21229 4107 Wilkens Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ MYOCHEDIAL HOUR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy 1 Tyes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ST. NONUS HOSPITTE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar mo

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CHARLES

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:48 7 LEON ROBERT TAYLOR, JR. Febru 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Anne Glen washington If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday 1 X M 2 □ F 215 56 68 Director 1931 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No Anne Arundel Pasadena 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 256 Wanda Road 21122 U.S.A. ral", or items 2 Examiner mus Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Machine Operator Allied Contractors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leon Robert Taylor, Sr. Marie E. Willing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20040 Ridge Meadow Rd Stewartstown, PA 17363 Barbara Peterson - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cem 2/20/2012 Baltimore, MD 22. Name and Address of Facility GJ Gonce Funeral Home, PA 169 Riviera Drive Pasadena, MD 21122 21. Signature of Euneral S. ce Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death pch lin shock, or heart failure. List only one caude Immediate Cause (Final Physician! disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No signed by the atte Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed To the Hospital or Attending Physician: The law require within 24 hours after death.
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check red at the time, date and place, and due to the ca Certifying Nurse Practioner: To the best of my knowledge, death occ 29b. Signat and fitle of certifi 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 301

State Registrar 32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 5123c State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lee Hutchins Underwood February 17,2012 3:10P.M. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Riverview Nursing Home **Fssex** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Davs Hours March 24,1963 Baltimore, MD. 220-54-5357 48 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location death with the Maryland 10a. State 10d. Inside City Limits Director 1 🗆 Yes 2X No Maryland Baltimore County Essex 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? "natural", or items 23a or Funeral 21221 1 Eastern Blvd. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White 3 Divorced 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the 12 Security Guard Security 04 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be nent of Health and Menta Raymond Lucas Underwood, Sr. Dorothy Lee Hutchins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mr.Raymond L.Underwood, Jr. (Pro.) 13101 Manor Road Glen Arm, Maryland 21057 If item 27 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Harford County) Date cemetery, crematory or other place)

Evans Pineral Chapel and
Cramation Services, Inc. permit. Page 1
Department of
Important: If it
any injury or o Sunday, Feb. 19, 2012 1 Burial 2 X Cremation 3 Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Leffrey L. Gair, Sr. Cl. Sp. 22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A. /h Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 23a. Pt. 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph si ian Ovomary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Type II if any leading to immediate cause. Enter Underlying Diabetes Mellitus Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for Month Dav Year ed by the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes XX No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 performed? Yes 2 N 1 Yes 2 No 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Z No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a d litle of certifie 29c. License numbe 29d. Date signed (Month, Day, Year,

DHMH 17 Rev 7/2009

State Registrar

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31. Date filed (Month, Day, Year) FEB 2 1 2012

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Boltimare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician February 18, 2012 1:00 A M Dominic J. Villa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Franklin Woods Baltimore County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F February 6, 1920 Baltimore, Maryland 92 220 05 2699 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 □ Yes 2 □ X X 0 Director Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 23a or Examiner must be 21128 LISA 9504 Unit B Amberleigh Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or Items 11 Marital Status Black, White, etc. filed within 72 hours after 1√√Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 💢 Specify: ģ 3 Widowed 4 Divorced WW II White "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the 12 Self Employed Lawyer and Mental Hygid is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marianna Provini Pietro Villa Pages 1 and 2 should ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 9504 Unit B Amberleigh Lane Perry Hall, Maryland 21128 Jessie M. Villa (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc February 21 2012 Baltimore Marvland 21. Signatule of Funeral Service Ligansee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC LUNG CANCER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, larry leading to in media, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) physician Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 24a. Was an certificate has autopsy performed? res 2 No Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Ne 1 Inpatient 2 ER/Outpatient 3 DOA P Division or After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation ie Hospital or Attendi 24 hours after death. e Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9105 FRANKLIN SQUARE DRIVE, BALTIMORE, MD

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 6 = 56 AM Physician/ 2012 Fet Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/A Center saltimore of Maryland Medical 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 24 Hrs 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Salisbury MD APR 12 1952 Director 1 🛛 M 2 🗆 F 59 1.4_60_8596 sual Residence of Deced 10d. Inside City Limits 28a-f show 10c. City, Town or Location must be notified at by Funeral Director Atlantic VA Accomack 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò USA 23303 9285 Atlantic Rd items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. and Mental Hygiene.
Is marked other than "natural", or item Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married white 1 Yes 2 No Specify. Maryland 21215-0036 Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) restaurant manager 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Sarah Weddells Stwart ပ္ Waterfield John William t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9285 Atlantic Rd Atlantic VA 23303 19a. Informant's Name/Relationship (Type, Print) Teresa Waterfield Department of Healt Important: If item 2 any injury or other t Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Temperanceville VA 2/21/12 John W Taylor 4 Donation 5 Other (Specify) 22. Name and Address of Facility permit. Fox Holston Funeral Home once, City Rd Chincoteague, VA 3059 Chicken athat based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part 1. Enter the disease, or complication Interval Between shock, or heart failure. List only one ca Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine no langio con To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant Month Day in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28d. Describe how injury occurred Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work? 1 Yes 2 No Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 53 2

Registrar DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

| | 1- For State Certif | ment of Health and Mental F icate of Death | lygiene Reg. No. 2 (| 012 01.0 |
|---|---|--|--|---|
| Physician/ Medical Examiner | 1. Decedent's Name (First, Middle,Last) Tyecha Lave Williams Tyesha Lave | tte Williams | 2. Date of Death Month Day Year February 18, 2012 | 3. Time of Death 0231 hrs |
| ,- | 4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center | 4b. City, Town, or Location of Deal Cheverly | | |
| Funeral Director | 5. Social Security Number 217-39-0621 6. Sex 17. Age (In yrs. last I | oirthday) If Under 1 Year If Under 24Hi Months Days Hours Mi | · 1- | Birthplace (State or or oreign Country) Maryland |
| ter death with the Maryland ", or items 23a or 28a-f show any er must be notified at once. / Funeral Director | MD St. Mary's Lexin 10e. Street and Number 21552 Port Court 11. Marital Status 12. Was Decedent Ever in U.S. | mnor Location gton Park 10f. Zip Code 20653 13. Was Decedent of Hispanic Origin? (S | | merican Indian, Black, |
| 2 hours at "natural I Examin | 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16 Elementary/Secondary (0-12) 1 2 t h | If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No specify: a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re Student | work done liced) None | lack |
| MD 21215-0036 at 2 should be filed within 7 th and Mental Hygene. a 71 is marked other than numarite event, the Medica To Be Comple | 17. Father's Name (First, Middle, Last) Timothy Williams 19a. Informant's Name/Relationship (Type, Print) | Tamala 1 | Rural Route Number, City or Town, S | state, Zip Code) |
| Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 77 is in injury or other traumatic | 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Plac crem Metr | 21552 Port Ct. Lexing e of Disposition (Name of cemetery, natory or other place) opolitan Crematory 2/2 | Date 20c. Location - City Alexandr: | y or Town, State |
| Physician | 21. Signature of Funeral Service Licensee 23. Part I. Enter the disease, or complications that caused the death. Do | 4308 Suitland Road | arshall-March Fune | |
| /Medical Examiner | failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate a. Chest and Abdominal Injuration to consequence of: Due to (or as a consequence of): Due to (or as a consequence of): | | | Between Onset and Death |
| pe executed tician and untal - transit edical Examiner | cause. Enter Underlying Cause (Disease of hijury that initiated events resulting in death) Last Due to (or as a consequence of): d. | | | |
| D. Box 68760, the death certificate be executly the death certificate be executly the attending physician and other for use as the burial - transfer of the second for the | UNPENDED AMENDED #1perME, G IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 | 925 , 3/1/2012 , WS 2 | 23d. Date of delifemency Month | ivery Day Year |
| P.C es that gened by | Part II. Other significant conditions contributing to death but not result | ing in the underlying cause given in Part I. | | Probably 4 Unknown e autopsy findings available to completion of cause of |
| n of Vital I sing Physician: After this certiff funeral director, on: To Be (| (Month Day Year) | 26. Place of Death (Check Outpatient 3 DOA Other4 Nursi D. Time of Injury 128c. Injury at Work? 17 hrs 1 Yes 2 No | only one) ng Home 5 Residence 6 On 28d. Describe how injury occurred Passenger in auto/auto colli | |
| O Fill bound | 2 Accident 3 Suicide 6 Could not be determined (Specify) Local Street 28e. Place of Injury - At home, (Specify) Local Street | farm, street, factory, office building, etc. | 26f. Location (Street and Number or or Town, State) Suitland Road & Stoney Meadov | w Drive, Suitland, MD |
| To the Hospital within 24 hours: To the Funeral completely filled Medical Cert | Check only 1 Certifying Physician: To the best of my knowledge, construction on the basis of examination and/o and manner stated. | | | o the cause(s) |
| | 30 Name and address of person who completed cause of death (Item 23a | • | February 18, 2 | |
| State Registrar | Laron Locke MD. Assistant Medical Examiner 90 31. Date filed (Month, Day Year) 32. Registrar's Signature | 00 W. Baltimore Street, Baltimore, | VID 21223 | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#8, 17, perFH, G924, 2/21/2012 WS
State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 8:22 AM 2012 Richard W. Weirich Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEI Glen Burnie Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 🗓 💥 2 🗆 F Months Days Hours Min (Month, Da Feb 13, **Director** 276-24-1021 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits rector 1 ☐ Yes 2√X No Massillon OH Stark Ξ ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be Funeral 13721 Millersburg Rd 44647 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Y Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White 3 ★ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working d 2 should be filed within 72 alth and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Super Intendent / Mechanic Steel Manufacturing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip 2 Electa Woods Phillip Weirich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or any 8435 Kellydale St., NW, Massillon, OH 44646 Daughter Debra A. Lowe 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 KRemoval from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Rosehill Mem Garden Feb 18, 2012 Massillon, OH 22. Name and Address of Facility ure of Fun ral Fink Funeral Home, P.A 426 Crain Nwy S. Glen Burnie, MO1148 MD 21061 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mu disease or condition Medical resulting in death) D e to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Exami physician and sthe burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 Yes 2 Unknown g Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate I 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 X No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No iniury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 00327 2012 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 301 D 100 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Month 02 - 16 MAGGIE LEE WILLIAMS 1:36 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPICE GILCHRIST BALTIMORE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 217-50-3904 Director 1 🗆 M 2 🗶 F 62 Yrs. 11-12-1949 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits by Funeral Director notified MD 28a-f BALTIMORE 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ,s 23a o, must h USA 6138 MACBETH DRIVE 21239 permit, Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or it edical Examine Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK Completed 3 Divorced 4 Divorced I Hygiene. other than "natura ent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 1ACHINE OPERATOR 12 Ith and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ WILLIAMS DORETHA BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i HUSBAND 6138 MACBETH DR. BALTIMORE, MO. 21239 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State d Jo Department of Important: If it any Injury or c 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/25/12 BALTIMORE, MD KING MEMORIAL PACK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN EKKENE FUNERAL SCUS PA of Fineral Service Licenses YORK ROAD. BANIMORE, MD, 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. non small cel Immediate Cause (Final Project and Death Physician/ disease or condition Medical resulting in death) Due to (or as a correquence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ **Director:** After this certificate has been signed by the atter d in by the funeral director, page 2 should be detached for a in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: ၉ 4 Nursing Home 5 Residence 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar (Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NV

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| | | | For State Registrar | State of Maryland | d / Depa <i>Cer</i> | artment of H tificate of L | Health and N Death | | giene Reg. No. 2 (| 12 | 049 | 119 |
|---|---|-------------------------------------|---|--|---|---|---|--|--|--|--|------------|
| Р | hysicia Medic | | Decedent's Name (First, Middle, Last) Pa | aul H. | | Wr | right,Jr. | 2. Date of Dea Month Feb | | Year L 2 | 3. Time of De 3; 03 | eath M |
| | Examin | | 4a. Facility Name (if not institution, give st 400 Lorraine Ave | nue | | Essex | r Location of Death | | 4c. County Balti | of Death | | |
| Di | uneral rector | | 5. Social Security Number 217-54-1209 Usual Residence of Decedent | 7. Age (<i>ln yrs</i> , <i>la</i> | st birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt Sept. I | | | lace (State or Fo Nand | oreign |
| Baltimore, Maryland 21215-0036 semit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. | Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u> | To Be Completed by Funeral Director | 10a. State 10b. County MD Bal 10e. Street and Number 400 Lorraine Ave | enue 12. Was Decedent Ever in U.S. Armed Forces? 1 | 13. v 16a. Decece (Give I life. Di Elec 19b. Mailir 205 ace of Dispo | Vas Decedent of H f Yes, specify Cuba Yes YNo Vas Decedent of H f Yes, specify Cuba Yes YNo Jent's Usual Occup kind of work done of D NOT use retired) trical Er g Address (Street to P Jasmine sition (Name of natory or other plac | ation during most of work ngineer 18. Mother's Nam Helen and Number or Rure Road D | ing e (First, Middle, Marie al Route Number undalk, Date 0/2012 | Specify. 16b. Kind of Bi Baltin Electi Maiden Surname Wagner 7. City or Town, S Marylar 20c. Location- Sykesy | What Count I Stat I Stat I State I Whit I Whit I State | tes an Indian, ttc. te ustry Gas 1222 wn, State , MD | |
| Exa | itysician and ithe burial-transit | dical Examiner | 23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to himselfist cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last | cause on each line. | Y Co ence of): C.Also ence of. | 41 | INFAR | | Approximate Interval Betwee Onset and Dea | | | |
|). Box 6876 the death certificate | ed by the attending phy detached for use as th | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | Sc. If yes, outcome of pregnan 1 | death 3 L | Ectopic pregnanc Other (specify) | ру | | 23d. Da Mo | te of delive | ry Day Year | r |
| ecords, law requires | has been sign je 2 should be | Completed by P | Part II. Other significant conditions con | tributing to death but not resu | lting in the u | nderlying cause giv | ven in Part I. | 1 🗆 ` | rmed? | 3 Prob | ably 4 Unk sy findings avai npletion of caus | known |
| on of Vital Finding Physician: Tath. | certific rector, | To Be | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | ospital: 1 ☐ Inpatient 2 ☐ E 28a. Date of injury (Month, Day, Year) | ER/Outpatien 28b. Time of injury | t 3 DOA Other | 4 ∐ Nursing Ho y at | k only one) | lence 6 Other | er (Specify) | | |
| Division o Hospital or Attending | ral Directo | al Certificate: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At hon building, etc. (Specify) | | | | City or Tow | | | | |
| To the Hospi | To the Funeral Director: After this completed filled in by the funeral di | Medical | (Check 2 Medical Examine | cian: To the best of my knowle ar: On the basis of examination Practioner: To the best of my | and/or invest | igation, in my opinic leath occurred at the 29c. License | on, death occurred at e time, date and place | t the time, date a ce, and due to the | nd place, and due | to the caus | se(s) and manne ted. | er stated. |
| | 15 | | 30. Name and address of person who cor | €,9106 FH | 1LAD | rint) | . 2 | Sui | te Do | 0,6, | भाग ग | D'21. |
| R | Stat Registra | | 31. Date filed (Month, Day, FEB 2 1 | 2012 Registrar's Signatu | ire A. | barrel | | , | | | | |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 04920 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Belle Wayson 38 Mary Medical - LBRUAMY 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Medical altimore 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 10/26/1927 1 M 2 X F Yrs. 215-24-0237 **Director** 84 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Glen Burnie MD Anne Arundel 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 21061 U.S.A. Stewart Avenue 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceden... Armed Forces? Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file မ Mary Bartley Moon Joseph F. Woodard 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Pasadena, Maryland 21122 Mrs. Linda L. DeMario 8559 Chris Court, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Meadowridge Mem Park | 02/21/2012 Elkridge, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. M01357 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ NON STEMI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner YACE RAININ Sequentially list conditions cause. Enter Underlying Exami PNEHMONIA Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed certificate 2 No Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending ☐ Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated S 🗔 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 10055703 17,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A Gur guilant mes

State Registrar MIMON

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| | | | State Registrar | | Cer | tificate of D | Death | | Reg. No. 2 | 12 | 04921 |
| | Physicia | n/ | Decedent's Name (First, Middle, Last) | | | | | Date of De Month | | Year | 3. Time of Death |
| | Medic | | Kenneth Lee Will: 4a. Facility Name (If not institution, give s | | | 4b. City, Town, or | Longtion of F | Febru | ary 20, | 2012 | 5:10 a ^M |
| | Examin | er | Gilchrist Hospice | reet and number) | | Columb | | Death | Howa: | _ | |
| - gen | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. Ia | ast birthday) | If Under 1 Year | If Under 24 | | th | 9. Birthp | lace (State or Foreign |
| | Director | | 215-32-9770 | L M 2 □ F | Yrs. | Months Days | Hours 1 | Viin. (Month, Da | | Count | |
| | T ow | | Usual Residence of Decedent 10a, State 10b, County | 76 | T | | | Nov. 5 | , 1935 | | ryland |
| | ryland -f sh ied a | cto | , | | y, Town or Loc | cation | | | | 110 | 0d. Inside City Limits 1 ☐ Yes 2 🔀 No |
| | e Ma r 28a notif | Director | Maryland Harford 10e. Street and Number | Edd | gewood | 10f. Zip Code | | | 10g. Citizen of W | /hat Cour | |
| | vith th | | 1912 Harbinger T | cail | | 21040 | | | USA | nat Count | u y i |
| | ems ems | Funeral | | 12. Was Decedent Ever in U.S | | Vas Decedent of His | spanic Origin' | ? (Specify Yes or No- | | e - America | an Indian, |
| 36 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by | 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 Yes 2 □ No If Yes, Give | - 1 | Yes, specify Cubar | | uerto Rican, etc.) | | k, White, e Whi | etc. |
| 21215-0036 | hours natura ical E | Completed | 15. Decedent's Edu | | 16a, Deced | ent's Usual Occupa | ation | | 16b. Kind of Bu | | |
| 215 | n 72 e. an "r Med | mo | (Specify only highest grade Elementary/Secondary (0-12) | e completed) College (1-4 or 5+) | (Give F life, D | ind of work done d O NOT use retired) | luring most of | working | | | , |
| 7 | with giene ner th t, the | | 9 | | Truck | Driver | | | Concr | ete | |
| п | e filed tral Hy ed orth even | To Be | 17. Father's Name (First, Middle, Last) | | | | | Name (First, Middle, | <i>'</i> |) | |
| 훒 | uld be d Mer narke natic | _ | Glen Martin Will: | | _ | | | M. Kitzm | | | |
| Maryland | 2 sho th and 27 is I traur | | 19a. Informant's Name/Relationship (Typ Marlene Willig / V | | . 1 | | | r Rural Route Numbe | | | |
| | of Heal | | 20a. Method of Disposition | 20b. P | lace of Dispo: | sition (Name of natory or other place | | Date | 20c. Location - | | |
| ij | Page ment ant: It | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 🔀 Other (Spec | terrioval from State | | Memorial | i . | -23-12 | Bel Air | , Mar | yland |
| Baltimore, | permit. Departi Import any inj | | 21. Signatu / f Funeral Service License | Quidi) | Mc | Name and Addres | s of Facility neral | Home, P.A d., Abing | · MD | 21.000 | |
| | | | 23a. Part 1. Enter the disease, or compli | | | | | | | | Approximate |
| - | Physicism/ | | shock, or heart failure. List only one Immediate Cause (Final disease or condition | cause on each line. | Post | CEO | | | | | Interval Between Onset and Death MONTHS |
| | Medical Examiner | | resulting in death) | Due to (or as a co) sequ | ience of): | ULA | | | | | 1110101112 |
| | | Je. | Se uentially list conditions. | | | | | | | _ | |
| | ed isit | mine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ | ience of): | | | | | | |
| | xecute n and al-trar | Examiner | that initiated events resulting in death) Last | Due to (or as a consequ | ience of): | | | | | | · · · · · · · · · · · · · · · · · · · |
| 09 | cate be executed physician and s the burial-transit | edical | | ı | | | | | | | |
| | ificate g phy as the | | IS SELVICE | | | | | | | | |
| õ × | endin r use | an/I | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | Bc. If yes, outcome of pregna | | Ectopic pregnanc | ٧ | | | e of delive | * |
| Division of Vital Records, P.O. Box 687 | r the att | by Physician/M | In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 ☐ Pregnant at time of c 9 ☐ Unknown | | Other (specify) | , | | Mor | ith I | Day Year |
| P.0 | that th | y Ph | Part II. Other significant conditions con | tributing to death but not res | ulting in the u | nderlying cause giv | en in Part I. | 23e. Did t | obacco use contri | bute to the | e cause of death? |
| dS, | quires en sign ruld b | ed k | | | | | | 1 🕱 | Yes 2 No | 3 🗌 Prob | ably 4 🗆 Unknown |
| Sor | aw rec as bee 2 sho | Completed | | | | | | 24a. Was | | | sy findings available npletion of cause of |
| Ä | sician: The law r certificate has t lirector, page 2 s | Corr | | | | A-1-1-1 | | perfo | ormed? d | eath? | |
| ta | cian: ertific ector, | Be | 25. Was case referred to medical examiner? | ospital: | | | | Check only one) | | | , , |
| <u>=</u> | Physi this c | ٠ <u>٠</u> | 1 Yes 2 X No | 1 Inpatient 2 | ER/Outpatien 28b. Time of | | 4 L Nursi | ng Home 5 Resi | | | HOSPICE |
| o u | ding th. After fune | cate | 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation | (Month, Day, Year) | injury | 28c. Injury work' M 1 🗆 | | | now injury occurre | a | |
| Sio | Atter er dea ector by the | Certificate: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At ho building, etc. (Specify, | | | | | Street and Number | r or Rural i | Route Number, |
| 2 | ital or urs aftural Dir ral Dir | | | | | | | City or Tov | | | |
| | To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi | Medical | (Check 2 Medical Examina | cian: To the best of my knowledger: On the basis of examination Practitioner: To the best of m | and/or invest | igation, in my opinio | n, death occur | rred at the time, date a | and place, and due | to the caus | se(s) and manner stated. |
| | To th withir To th comp | 2 | 29b. Signature and title of certifier | | , | 29c. License | number | | 29d. Date signed | (Month, D | ay, Year) |
| | | | · ADUC | du | | 106 | 439 | 5 | FEBRU | LARY | 120,2012 |
| 1 | (| | 30. Name and address of person who co | mpleted cause of death (Item | 23a) (Type, P | rint) O CEDA | R LAN | VE CO | LUMB, | 1A, 11 | 18 21044 |
| | Stat Registra | | 31. Date filed (Month, Day, Year) FEB 2 1 2012 | 39 Registrar's Signat | | | | | | | |
| | negistra | | N T 7017 | Person A | MARI | Rad | | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

| | | | for State OT I | Maryland | • | artment of tificate of | | and IV | lental Hyg | iene _{eg. No.} 2 | 012 | 01,922 |
|--------------------------------|--|-----------------|--|------------------------------------|---------------------|--|----------------------------------|--------------|---------------------------------------|---------------------------------|--|---------------------------------|
| | Dharisis | | Decedent's Name (First, Middle, Last) | | | inouto of | Dodan | | 2. Date of Deat | h | UIC | 3. Time of Death |
| | Physicia Medic | al | Irene | Wile | eman | | | | February | y 19, | 20 Î 2 r | 5:17 A M |
| | Examin | er | 4a. Facility Name (if not institution, give street and number Brooke Grove |) | | 4b. City, Town | , or Location y Spri | | | 4c. County of Death Montgomery | | |
| | Funeral | | | Age (In yrs. las | t birthday) | If Under 1 Yea | ar If Unde | r 24 Hrs. | 8. Date of Birth (Month, Day, | 1 | | place (State or Foreign |
| | Director | | 298-20-3057 Usual Residence of Decedent | 86 | Yrs. | WOTENS Day | 170010 | 1 1 | Jan. 22, | | | io |
| | land show dat | tor | 10a. State 10b. County | 10c. City, | Town or Loc | ation | | | | | | 10d. Inside City Limits |
| | e Mary r 28a-i notifie | :≒ | Maryland Montgomery 10e. Street and Number | | 011 | ney | | | | | | 1 Yes 2 K No |
| | s 23a or | Funeral I | 4512 Random Ridge Circle | | | 10f. Zip Code 20 | * 832 | | | _ | of What Cou d Stat | |
| 9036 | within 72 hours after death with the Maryland jiene. sr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at | þ | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☎ Widowed 4 □ Divorced 12. Was Deceder Armed Forcer 1 □ Yes 2 □ If Yes, Gue Year or Dates | s? 🔀 No | If | Vas Decedent of Yes, specify Cu ☐ Yes 2 🗓 I | ıban, Mexica | ın, Puerto F | cify Yes or No- Rican, etc.) | | Race - Ameri Black, White, cify: Wh i | etc. |
| Baltimore, Maryland 21215-0036 | within 72 hou rgiene. ner than "nati ner the Medica | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 of 12) | | (Give k life. DC | ent's Usual Occ ind of work don NOT use retire emaker | e during mo | st of workir | ng | | of Business/Ir | ndustry |
| land 2 | e filed vital Hyg | To Be (| 17. Father's Name (First, Middle, Last) Maurice Joseph Murphy | | | | | | (First, Middle, M E lizabet | faiden Surn | ame) | |
| Mary | nould Ind M s mar umat | 2 | 19a. Informant's Name/Relationship (Type, Print) Mary K.W. Rafferty/Daughte | er | | | | | Route Number, | | | |
| imore, | permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra | | 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify) | cer | netery, crem | sition (Name of eatory or other p Cemeter | Jace) | Febru 201 | ary 25, | | on - City or T | |
| Balt | permit. Departr Import any inj | 3 | 21. Signature of June of Service Censee | M00198 | Ro 300 | Name and Add bert A. West M | ress of Facil Pumph ontgon | rey Fi | uneral H | ome/R kvi11 | ockvil e,Mar | le, Inc. yland 20850 |
| | | | 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each | sed the death. line. | | | | | | | | Approximate Interval Between |
| | Physician/ Medical | | requiting in death) | phera1 | | ial Dis | ease | | | | | Significant Death Years |
| | Examiner: | L | | | | Cardio | myopat | hy | | | | |
| | sit sit | nine | If any, leading to immediate Due to (or a | Absces | | | | | | | | |
| | xecute n and al-tran | Еха | that initiated events c | as a consequer | | | | | | | | |
| 90 | cate be executed physician and s the burial-transit | edical Examiner | d | | | | | | | | | |
| Box 68760 | | Physician/Me | | h 2 ☐ Fetal o it at time of dea | death 3 🗌 | Ectopic pregna Other (specify) | | | | | Date of delive | ery Day Year |
| , P.O. | es that the igned by be detac | ρλ | Part II. Other significant conditions contributing to death | but not result | ting in the ur | nderlying cause | given in Par | t I. | | | | he cause of death? |
| ords | requir been s should | letec | | | | | | | 24a. Was an | | | bably 4 Unknown |
| l Reco | n: The law ficate has or, page 2 | Completed | 25. Was case referred to medical | | | | | | autops perform 1 Yes 2 | y ned? | prior to co death? 1 \(\sum \) Yes | impletion of cause of |
| Vita | ysicial is certi directo | To Be | examiner? Hospital: | atient 2 🗌 Ef | R/Outpatient | 10 | Place of Deather: | | only one) ne 5 □ Residei | nce 6 🕱 (| Other (Specifi | Assisted |
| on of | ath. r: After th | Certificate: | 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of ir | njury 2 | 8b. Time of injury | 28c. Inj | | 2 | 8d. Describe hov | | | / DIVING |
| Division of Vital Records, | tal or Atters after de al Directo | | | njury - At hometc. (Specify) | e, farm, stre | et, factory, offic | е | 2 | 28f. Location (Str City or Town, | | mber or Rura | l Route Number, |
| | the Hospi iin 24 hou the Funer apletely fil | Medical | 29a. Certifier (Check (Check only one) 1 ☑ Certifying Physician: To the best 2 ☐ Medical Examiner: On the basis of Certifying Nurse Practitioner: To | f examination a | nd/or investi | gation, in my opi | nion, death o | ccurred at t | the time, date and | place, and | due to the ca | use(s) and manner stated. |
| | 6 7 × N | | 29b. Signature and title of certifier | | | | nse number | 123 | | _ | 20 — 1 | |
| | 10 h. | | | Princ | e Phi | _{int)} lip Dri | | | Olney, | Mary1 | and 20 | 832 |
| | Stat Registra | e ir | 31. Date filed (MFE Bay 2°1 2012 22. Regis | strar's Signatur | far | Kel | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #8 Per FH C924 2/21/2012 Jh
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2012 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner USA JENESIS TIMORT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **J**(**1/1**), Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 94 250-05-5551 Director 16,1917 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If item 27 is marked other than "natural", or Items be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5200 Bowleys Lane Apt.115 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Self Employed <u>Child Care Provider</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosmond Wheeler Selena Means ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona Wheeler (daughter) 1602 E. Lanvale St. Balto, Md. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park Feb. 23, 2012 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Balto, Md. 4 Donation 5 Dother (Specify) Calvin B. Scruggs Funeral Home rvice Licens e E. Preston St. Balto, Md. 23a. Part1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Mexistatic Discovered adenocare /Medical 2/13/2012 Due to (or as a consequence of): Examiner Osquentially flot conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b 24a. Was an 1 Yes 2 X No 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 🗌 No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -LIAM-

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 1 2012

32. Registrar's Signat

| | | | For State | State of | Marylan | | artment o | | | 1ental Hy | | 2012 | 04924 |
|--------------------------------|--|--------------|--|--|-----------------------------------|-----------------------------------|---------------------------------|------------------------|------------------------|----------------------------------|--------------|-----------------------------|---|
| | Physicia | in/ | Registrar 1. Decedent's Name (First, Middle) | , , | D O MILLY | | | | | 2. Date of De | Day | | 3. Time of Death |
| g. va. | Medic | cal | 4a, Facility Name (if not institution | | ROTHY | MAKI | | VLK vn, or Location | on of Death | Februa | | 2012 County of Dear | |
| - | Examin | ler | | instru Mel | - | tes | روم ا ی | _ | | | | | CUNDEL |
| | Funeral Director | | 5. Social Security Number 220 14 5649 | | '. Age (In yrs. Ia | | If Under 1 \ Months D | ear If Undays Hour | der 24 Hrs, rs Min. | 8. Date of Bir $0.8^{Month, Da}$ | th | 9. Bir | thplace (State or Foreign ountry) |
| | show dat | ğ | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | ation | | | | | | 10d. Inside City Limits |
| | Mary 28a-f notifie | Director | | Arundel | Pa | saden | | | | | | | 1 ☐ Yes 2 💆 No |
| | rith the 23a or st be r | ral | 10e. Street and Number 7706 Lee Dri | 17.0 | | | 10f. Zip Co | | 1122 | | - | zen of What Co U • S • A | |
| | eath w | Funeral | 11. Marital Status | 12, Was Deced | | | | of Hispanic | Origin? (Spe | cify Yes or No- | | 14. Race - Ame | erican Indian, |
| 36 | e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Completed by | 1 ☐ Never Married 2 ☐ Marri 3 🔀 Widowed 4 ☐ Divorced | If Yes, Give | 2. 🔀 No | | Yes, specify | | | Hican, etc.) | S | Black, Whit | _{e, etc.} hite |
| 2-00 | hours natura dical E | olete | 15. Deceder | Year or Date nt's Education st grade completed) | es. | | ent's Usual O | | | - | 16b. Kir | nd of Business | |
| Baltimore, Maryland 21215-0036 | thin 72 ene. than " | Somp | Elementary/Seconday (0-12) | College (1-4 | l or 5+) | life. Do | aind of work d O NOT use ret | ired) | nost of Worki | ng | E a d | onel. | Carramant |
| d 2 | be filed wi ental Hygie ked other ic event, ti | Be | 17. Father's Name (First, Middle, L | .ast) | | sec. | retary | | other's Name | e (First, Middle, | • | | Government |
| ylan | should be file and Mental is marked or raumatic eve | 욘 | | Raymo | nd J. | Dum1 | er | A | nna (| . Hok | amp | | |
| Mar | bou and s u | W | 19a. Informant's Name/Relations! Barbara Taylo | | htor | 1 | g Address (St Lee | | | Route Numbe | - | Town, State, Zi, | |
| Ē, | | | 20a. Method of Disposition | | 20b. P | lace of Dispo | sition (Name o | of | T | Date | | cation - City or | |
| imo | Page 1 | | 1 🔀 Burial 2 🗌 Cremation 4 🔲 Donation 5 🗌 Other (S | | naic | _{emetery, cren} Latka | | | 2 18 | 12 | Pala | tka, | F1 |
| Balt | permit. Page Department of Important, If any injury or once. | | 21. Signature of Funeral Service | ficensee | | 100 | Name and A | | G | Gonc e Pa | e Fu sade | neral na, M | Home, PA D 21122 |
| | | | 23a. Part 1. Enter the disease, or shock, or heart failure. List of | complications that ca | used the death h line. | n. Do not ente | r the mode of | dying, such | as cardiac c | r respiratory ar | rest, | | Approximate Interval Between |
| ,,,,,, | h, i i n Medical | | Immediate Cause (Final disease or condition resulting in death) | _ a. | r as a consequ | | | | | | | _ | Onset and Death |
| | Examiner | | Sequentially list conditions, | bue to (or | as a consequ | erice oi). | | | | | | | |
| ^ . | p #s | Examiner | if any, leading to immediate cause. Enter Underlying | Due to (or | r as a consequ | ence of): | | | | | | | - |
| SP | xecute n and al-tran | Exar | that initiated events resulting in death) Last | c. Due to (or | r as a consequ | ence of): | | | | | | | |
| 09 | ate be executed bhysician and the burial-transit | dical | | d | | | | | | | | | |
| | eath certifical attending ph I for use as th | /Me | IF FEMALE: | 23c. If yes, outco | ome of pregnar | ncv | | | | | | | |
| . Box 687 | 9 90 | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 1 Live Bi | irth 2 🗀 Feta ant at time of d | Ideath 3 | Ectopic pred Other (speci | | | | | 23d. Date of de Month | Day Year |
| s, P.O. | igr be | | Part II. Other significant condition | ons contributing to dea | ath but not resu | ulting in the u | nderlying cau | se given in P | art I. | 23e. Did to | | | the cause of death? |
| Division of Vital Records, | e law require has been s ge 2 should | Completed by | | | | | | | | 24a. Was | | 24b. Were au | topsy findings available completion of cause of |
| Re | : The la | | | | | | | | | perfo | 2 No | death? | s 2 No |
| /ital | ysician: The is certificate director, pag | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | Hospital: | npatient 2 🗆 | ER/Outpatien | | Other: | Death (Check | only one) me 5 🗆 Resid | d-m 6 | Other (0000 | |
| of | ng Phys fter this meral di | | 27. Manner of Death 1 Natural 5 Pendin | 28a. Date of | | 28b. Time of injury | | Injury at work? | | 28d. Describe h | | | :iiy) |
| sion | ttendi death. ctor: A y the fu | Certificate: | 2 Accident Investig | gation not be | f Injury - At ho | me farm stre | | 1 Yes 2 | | 28f Location (| Street and | Number or Ru | ral Route Number, |
| Divi | Hospital or Attending 24 hours after death. Funeral Director: After eted filled in by the funer | | 4 Homicide determ | | g, etc. (Specify) | | ot, idotory, or | | | City or Tow | | Number of Nu | rai noute Nambei, |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral | Medical | (Check 2 Medical E | Physician: To the best examiner: On the basis Nurse Practioner: To | of examination | and/or invest | igation, in my | opinion, deatl | h occurred at | the time, date a | and place, | and due to the | cause(s) and manner stated. |
| _ | To the within 2 To the comple | _ | 29b. Signature and title of certifier | | | | | cense numbe | | | | e signed (Mont | |
| | 1 | | 30. Name and address of person v | Marca Ma | of death /Itam | 23a) (Tupo P | | 274 | | | reb. | runry | 11,2012 |
| | ١ | | 1 4 | ANCIS, | BA | 1 simo | e W | shin | is ton | Mesic | al | Cente | 2~ |
| | Stat Registra | | 31. Date filed (Month, Day, Year) FEB 2 1 2 | 012 July | gistrar's Signat | har | Les . | | | | | | |

| | | | For State of Mary | | | | Mental Hyg | giene | 0.1.0 | 01000 |
|----------------------------|---|-----------------|--|----------------------------|--|----------------------------------|--|------------------------|---|--|
| | | | State Registrar | Cer | tificate of L | Death | | Reg. No. | 012 | 04925 |
| H | Physicia Media | | 1. Decedent's Name (First, Middle, Last) John Byron Wagner Jr | • | | | 2. Date of Dea Month Feb 17 | Day | 2 Year | 3. Time of Death 17:21p M |
| with the same | Examir | | 4a. Facility Name (if not institution, give street and number) | | 4b. City, Town, or | Location of Dea | 15 5.5 | | nty of Death | |
| Also and | | м | Carroll Hospital Cente | | | minster | | | roll | |
| * | Funeral Director | | 219-12-0409 1× M 2 🗆 F 89 | yrs. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hr. Hours Mir | | ; Year) | Coun | place (State or Foreign try) |
| | nd how at | ٦ | Usual Residence of Decedent 10a. State 10b. County 10 | c. City, Town or Loc | cation | | 11-13 | -22 | MD | 10d. Inside City Limits |
| | faryla 8a-fs tified | Director | MD Carroll | | West | minste | r | | | 1 🗆 Yes 2 🗷 No |
| | the N | | 10e. Street and Number | | 10f. Zip Code | | | 10g. Citizen o | f What Cour | ntry? |
| | h with 1s 23a nust l | Funeral | 2332 Old Washington Ro | | 2 | 1157 | | USA | | |
| Maryland 21215-0036 | ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | Completed by Fu | 11. Marital Status 1 □ Never Married 2 ♣ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ♠ No If Yes, Give Year or Dates. | If | Vas Decedent of Hi f Yes, specify Cubar | | Specify Yes or No- to Rican, etc.) | В | ace - Americ lack, White, fy: whit | etc. |
| 15-(| 72 hou "nat edica | ple | 15. Decedent's Education (Specify only highest grade completed) | (Give k | ent's Usual Occupa aind of work done d | | orking | 16b. Kind of | Business/In | dustry |
| 12 | iene. r thar the M | Con | Elementary/Secondary (0-12) College (1-4 or 5+) | 1 | NOT use retired) | | | Farmi | ng | |
| ρ. | filed wall Hyg | Be | 17. Father's Name (First, Middle, Last) | | | | ame (First, Middle, I | | | |
| ylar | Id be Menta arkec aric e | 10 | John B. Wagner Sr. | | | Lena | Zepp | | | |
| , Mar | nd 2 shou ealth and m 27 is m | | 19a. Informant's Name/Relationship (Type, Print) Louise Wagner-wife | 19b. Mailin 2332 | g Address (Street a Old Was | nnd Number or R Shingto | ural Route Number, n Rd., W | City or Town, estmi | State, Zip (nster | Code) 21157 , MD |
| | Par Fr | | 1 Burial 2 ☐ Cremation 3 ☐ Removal from State | Zion Chu | atory or other place irch Cem | 1. 2-2 | | 20c. Location Shipl | ey,MD | |
| Balt | permit. Departri Importa any inju | | 21. Signature of Funeral Service Licensee | | | | etcher ,Westmi | | | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the shock, or heart fallure. List only one cause on each line. | death. Do not ente | r the mode of dying | g, such as cardia | c or respiratory arre | est, | | Approximate Interval Between |
| it. | h, i i.an Medical | | Immediate Cause (Final disease or condition resulting in death) | 4311 | <u> </u> | | | | | Onset and Death |
| | Examiner | | Due to (or as a cor | nsequence of): | | | | | | |
| | sit d | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | nsequence of): | | | | | | |
| | ate be executed onlysician and the burial-transit | Exan | Cause (Disease or injury that initiated events c. Due to (or as a cor esulting in death) Last Due to (or as a cor | nsequence of): | | | · | | - 1 | |
| 09 | s be e) /sician e burit | ical | L d. | | | | | | | |
| 876 | incate t ig phys as the | | IF FEMALE: | | | | | | | |
| P.O. Box 687 | ne death certificate be executed y the attending physician and iched for use as the burial-transi | | 23c. If yes, outcome of pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | Fetal death 3 | Ectopic pregnancy Other (specify) | у | | | ate of delive | ery Day Year |
| ls, P.O | uires tnat the dea n signed by the a uld be detached f | ed by P | Part II. Other significant conditions contributing to death but no | ot resulting in the ur | nderlying cause give | en in Part I. | | À - | | ne cause of death? |
| Division of Vital Records, | Ine law requires that the sate has been signed by th page 2 should be detach | Completed | | | | | 24a. Was a autops perfori 1 □ Yes | ned? | | osy findings available mpletion of cause of |
| e . | sician: The certificate irector, pag | Be C | 25. Was case referred to medical examiner? | | 26. Pla | ce of Death (Che | | ZZ-SINO] | 1 🗆 163 | 2 2 110 |
| ₹ | nysic his ce al dire | 욘 | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient | 2 ER/Outpatient | 3 DOA Other | r: 4 Nursing I | Home 5 Reside | ence 6 🗆 Ot | her (Specify) |) |
| on of | naing Pnysician: 1 ath. r: After this certifica ie funeral director, p | Certificate: | 27. Manner of Death 1 ★ Natural 5 □ Pending 2 □ Accident □ Investigation | ar) 28b. Time of injury | 28c. Injury work? M 1 🗆 | at Yes 2 \(\sum \text{No} \) | 28d. Describe ho | w injury occu | rred | |
| Division | our Prospiral or Attending Prysician, within 24 hours after death. To the Funeral Director After this certification plately filled in by the funeral director, | | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (Sp | | et, factory, office | | 28f. Location (St. City or Town | | ber or Rural | Route Number, |
| : | Io we nospital within 24 hours a To the Funeral I completely filled | Medical | 29a. Certifier (Check 2 Medical Examiner: On the basis of examinary or | nation and/or investi | gation, in my opinior | n, death occurred | at the time, date an | d place, and d | ue to the cau | use(s) and manner stated. |
| i | with Voit | | 29b. Signature and the of chaffier | - | Dec License | number 5 9 5 5 | 7 | 9d. Date sign | of (Month, I | Day, Year) |
| | 61 | | 30. Name and address of person who completed cause of death | (Item 23a) (Type, Pr | int) WA PWL | FRD | UESTM. | STER | mi | 21157 |
| | Stat Registra | ië: ir | 31. Date filed (Month, Day, Year) FEB 2 1 2012 | | | | | | | |
| | H 17 Day 06 0 | | - John Jo | 17 000 | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 04926 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month apan Juanita B. Anderson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Jospeh Richey Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Min 220-20-3384 Director 1 □ M 2 🗓 F Yrs 5-12-1927 MD 84 Usual Residence of Decedent 28a-f show 10b. County 0a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified 1 🗌 Yes 2 🔀 No Pikesville MD Baltimore 10g. Citizen of What Country? 0 10e. Street and Number 10f. Zip Code 23a Funeral 21208 USA 4512 Mary Knell Road items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces? Black, White, etc. 6 þ 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify: African-American "natural", Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Juvenile Probation Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anne Tucker Lerroy Chew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 4512 Mary KNoll Road, Pikesville, MD 21208 Terry L. Anderson/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or othe King Memorial Park 1 Burial 2 Cremation 3 Removal from State 2-22-2012 Woodlawn, MD 4 Donation 5 Dther (Specify 21. Signature 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate 4 Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Anderson Exami burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the at Juanita Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é mellen 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Yes 27 Yes Division of Vital 25. Was case referred to medical or Attending Physician: e B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 A Other (Specify) 2| 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA Registrar's Sign State Registrar

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| | | | For | State of | Marylan | | artment of | | | 1ental Hy | giene | е | | 01.007 |
|--|---|--------------|--|---|--------------------------------------|---------------|--|-----------------------------|--------------------|--|--------------|---------------------------|--------------------------|---|
| | | | State Registrar | | | Ce | rtificate of | Death | | | Reg. N | o. 2 U | 12 | 04927 |
| ı | Physicia Medic | | 1. Decedent's Name (First, Middle, L Catherin | | ins | | | | | 2. Date of Dea Month | D | | Year 12 | 3. Time of Death 9 '. OSA M |
| | Examin | | 4a. Facility Name (if not institution, gi Seasons Hospice | ve street and numb | er) | | 4b. City, Town Randa | or Location | | | 4 | c. County o | f Death L timo | re |
| | Funeral Director | | | Sex 7 1 □ M 2 🕅 F | . Age (In yrs. Is | ** | If Under 1 Year Months Day | | er 24 Hrs. Min. | 8. Date of Birt (Month, Day 2–12–19) | y, Year) | | g. Birthp Count | olace (State or Foreign try) |
| | yland -f show ed at | ctor | Usual Residence of Decedent 10a. State 10b. County MD Balti | morre | | y, Town or Lo | | | | | | | 1 | 0d. Inside City Limits |
| | th the Mar 3a or 28a t be notifi | al Director | 10e. Street and Number 4771 Byron Road | | | | 10f. Zip Code | ± 21208 | | | 10g. C | Citizen of WI | | 1 \(\sum \) Yes 2 \(\begin{align*}{c}\mathbb{N}\) No try? |
| 36 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral | 11. Marital Status 1 Never Married 2 Married | 12. Was Decede Armed Forc 1 Yes 2 | es? | | Was Decedent of If Yes, specify Cu | f Hispanic (ıban, Mexic | an, Puerto | | | 14. Race Black | - Americ , White, e | etc. |
| 5-003 | Phours a "natural" | Completed | 3 🏿 Widowed 4 □ Divorced 15. Decedent's (Specify only highest) | Year or Date Education | es. | 16a. Dece | 1 Yes 2 X 1 dent's Usual Occ kind of work don | upation | | na | 16b. | Specify: (Kind of Bus | | |
| Maryland 21215-0036 | d within 73 ygiene. her than ht, the Me | Be Com | Elementary/Secondary (0-12) | College (1-4 | or 5+) | life. L | itress | ed) | | | | honey's | 5 | |
| yland | ald be filed Mental H narked ot natic ever | To B | 17. Father's Name (First, Middle, Last William Reardon | | | | | 18. Mo | ther's Name | e (First, Middle, | Maider | n Surname) | | |
| Mar | 2 shouth and the and the strain traum | | 19a, Informant's Name/Relationship | | | 1 | ng Address (Stre | | | | | or Town, Sta | ite, Zip C | (ode) |
| ē, | f Heal item ? | | Barbara Terzi/Daugh 20a. Method of Disposition | | | lace of Disp | Day Road, osition (Name of | | | Date | | Location - C | City or To | wn, State |
| Baltimore, | Page ment c tant: If ury or | | 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | 1010 | anev Va | matory or other p 11ev | | 2-22-2 | 2012 | Lut | hervil | le. M | D |
| Ball | permit Depart Import any in | | 21. Signature of Funeral Service Lieu | nsee | | 9 | 2. Name and Add 200 Libert | iress of Fac y Road | , Randa | ie Funera allstown, | 1 Ho MD | те Р.А 21133 | of | Balto. Co. |
| | | | 23a Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final | one cause on each | n line. | | | | | r respiratory arr | rest, | | | Approximate Interval Between Onset and Death |
| | Physician/ Medical | 1 3 | disease or condition resulting in death) | | as a consequ | | Inc Leuk | 2m10 | 1 | | | | | |
| | Examiner | ner | Sequentially list conditions, if any, leading to immediate | b. Due to (or | as a consequ | uence of): | | | | | | | | |
| | and -transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or | as a consequ | ience off: | | | | | | | | |
| 09, | cate be executed physician and the burial-transit | dical | | d | | | | | | | | | _ | |
| P.O. Box 687 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown | 23c. If yes, outco 1 ☐ Live Bi 4 ☐ Pregna 9 ☐ Unkno | rth 2 ☐ Feta int at time of c | al death 3 | Ectopic pregna | | | | | 23d. Date Mont | | ery Day Year |
| ls, P.O | uires that the signed by ald be deta | by | Part II. Other significant conditions | contributing to dea | th but not res | ulting in the | underlying cause | given in Pa | rt I. | 23e. Did to | | | | e cause of death? |
| Division of Vital Records, | The law req ate has bee page 2 sho | Completed | | | | | | | | 24a. Was autop perfo 1 Yes | osy rmed? | pr | ere autorior to coreath? | osy findings available inpletion of cause of |
| tal | Physician: The this certificate ral director, paç | Be | 25. Was case referred to medical examiner? | Hospital: | | | | A de la seri | eath (Check | | | | | ent hospice |
| of V | g Phys er this neral di | e: To | 1 🗆 Yes 2 🗖 No 27. Manner of Death | 1 In ln | injury | 28b. Time o | f 28c. In | ury at | | me 5 Resid | | | | 1001) 1103/110 |
| ion | tending death. tor: Afti the fur | Certificate: | 1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not | on he | Day, Year) | injury | M 1 | ork? | | | | | | |
| Divis | Hospital or Attending F 24 hours after death. Funeral Director: After stely filled in by the funer | | 4 ☐ Homicide determine | d 28e. Place o building | r injury - At no j, etc. (Specify | me, farm, st | reet, factory, offic | e | | 28f. Location (S City or Tow | | | or Rurai | Route Number, |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical | (Check 2 Medical Exa | nysician: To the bes miner: On the basis urse Practitioner: 1 | of examination | n and/or inve | stigation, in my op | inion, death | occurred at | the time, date a | nd plac | e, and due t | o the cau | use(s) and manner stated |
| | To the within 2 To the comple | | 29b. Signature and title of certifier MSRy APA | lnem.o | | | | nse number | 746 | | 29d. D | ate signed (| | |
| | | | 30. Name and address of person who N S Rajapak | completed cause | 283 | 5 60 | Print) | N | 570 | 3 Ba | Br | nore | MD | 21209 |
| State Registrar FEB 2 2 2012 32 legistrar's Signature S. January S | | | | | | | | | | | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2012 10:30 A M Wayne Patricia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under **Funeral** Months Days Hours (Month, Day, Year 220-26-6975 1 □ M 2 👿 F Director Maryland Jan. 4, 86 1926 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director notified 1 Yes 2 X No Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò be r items 23a ner must be Funeral United States 20877 107-A N. Summit Ave., 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 Widowed 4X Divorced the Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 73 Health and Mental Hygiene. Iem 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Company Administrator Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eleanor Browning Avis Emlen Paul Wayne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9917 Colorado Ct., Damascus, Maryland 20872 Donna Hill / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of ☐ Burial 2X Cremation 3 ☐ Removal from State Important: If any injury or once, Metro Crematory Inc. 02/18/2012 |Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Plly ician disease or condition resulting in death) Medical a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 L 9 Unknown 9 | Hoknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital Other: ည 2 No 1 Nanatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical 🖟 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certi completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dηly or 29b. Signatu 29d. Date signed (Month. Day, Year) 10067210 115/2012 person who completed cause of death (Item 23a) (Type, Print) Research Blud Rockwill & many knel 20850 2401 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb. Day Physician/ 2012 15 04:00 P M Albert L. Arnold Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Davs Hours Min Director 84 217-22-7918 1 ★ M 2 🗆 F Mar. 15, 1927 Maryland Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10a. State Director Catonsville 1 ☐ Yes 2 🏝 No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21228 USA 303 Maiden Choice Lane Apt. 322 2 should be filed within 72 hours arter occur.
th and Mental Hyglene.
27 is marked other than "natural", or items
27 is marked other than "hatural" or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 KNo Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Paper Splitter Paper Company n/a Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked any injury or other traumations. 2 Emma Thomas John Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Maiden Choice Lane Apt. 322 Catonsville, MD21228 Ramona Arnold/ Wife 3altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Feb 17,2012 Glen Burnie, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur SPring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ oulkinson 1225 disease or condition Medical resulting in death) Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical ul or Attending Physician: The law requires that the death certificate be a after death.

Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 page 2 Yes 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes hospice 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 \square Pending Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15 58303 resivary ATRON J CHALLES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 OK N. Charles ST TOWSON MO

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

FEB 2

barker

Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

| | | | se Type or Pri | | | | | _ | ble. | | |
|--|--------------------|--|---|-------------------------------------|---|--|-------------------------|--|-----------------------------------|--|--|
| | | 1 For Amend It | State of Material State of Material State of Material States | aryland / De | partment of 28a-f. per | Health and | Mental Hyg .02/22/20 | giene 012dhb () | 10 | 01.030 | |
| | | Registrar 1. Decedent's Name (First, Middle, | | | erimcale or | Dearr | 2. Date of Dea | - Sitter | 3. | Time of Death | |
| Physicia Medic | | George | Ainsu | orth | | | Month 2 | Day 2 | Year | 1837 M | |
| Examin | | 4a. Facility Name (if not institution, | give street and number) | | | or Location of Death | 1 | 4c. County of | | | |
| Funeral | | | imal Madica 6. Sex 7. Age | 1) COHCI e (In yrs. last birthda |) If Under 1 Year | | | n | 9. Birthplace | (State or Foreign | |
| Director | | 199142157 | 1 X M 2 □ F | O Yrs | Months Days | Hours Min. | (Month, Day | | Country) | 11 | |
| nd how at | ž | Usual Residence of Decedent 10a. State 10b. County | or Location | | |)1 4 d 1 | 10d. I | Inside City Limits | | | |
| Maryla 8a-f s rtified | rect | MD Wice | omico | C | ralishu | ru | | | - | 1 ¥Yes 2 □ No | |
| should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at | Funeral Director | 10e. Street and Number | 0 , 0 | | 10f. Zip Code | | | 10g. Ciţizen of W | 'hat Country? | | |
| ath wit | nner | 11. Marital Status | 12. Was Decedent E | ver in II.S 1 | 3. Was Decedent of | Hispanic Origin? (Sr | pecify Yes or No- | 14 Race | - American In | ndian | |
| ter de | by F | 1 Never Married 2 Marri | Armed Forces? | | If Yes, specify Cut | oan, Mexican, Puert | o Rican, etc.) | Black | k, White, etc. | idian, | |
| ours af tural" al Exa | To Be Completed | 3 Widowed 4 □ Divorced | If Yes, Give Year or Dates. | | 1 ☐ Yes 2 🕱 N | | | Specify: | Whi | te | |
| 72 hc | | 15. Decedent | st grade completed) | (Gi | cedent's Usual Occu ve kind of work done DO NOT use retired | during most of wor | rking | 16b. Kind of Bu | siness/Industr | У | |
| withir giene. ser the | | Elementary/Secondary (0-12) | College (1-4 or 5 |)+) | Lawye | 20 | | L | · · | | |
| e filed ntal Hy ed oth | | 17. Father's Name (First, Middle, La | ^ | - 41 - 0 | | 4 3 | me (First, Middle, | 1 . 1 | | 2.0 | |
| should be file n and Mental h is marked o raumatic eve | , | 19a, Informant's Name/Relationshi | ip (Type, Print) | | ailing Address (Stree | | ral Route Number | | ate. Zip Code | | |
| ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | | Devon Ainsu | worth day | whter 15 | 96 Qu | arcy Bo |) Yours | I'm | A = | 067 | |
| oermit. Page 1 and 2 Department of Health Important: If item 27 Injury or other th | | 20a. Method of Disposition 1 Derivation | 3 Removal from State | | position (Name of rematory or other pla | ace) | Dateunic | 20c. Location - | City or Town, | State | |
| Par Fr | | 4 Donation 5 ☐ Other (Sp. 21. Signature of Fineral Service Lie | | LiFe | 22. Name and Addr | matery | | Thoen | IIX, A | rizona | |
| permit. Departr Imports any inji | | 21. Signatur of thire at Service Lin | han 1 | / | MALT | 1232 | Midv | aller I | Dr Jes | SUP PA | |
| | | 23a. Part. Enter the disease, or of shock, or heart failure. List or | complications that caused nly one cause on each line | the death. Do not e | nter the mode of dy | ing, such as cardiac | or respiratory arr | est, | | proximate erval Between | |
| Physician/ | | disease or condition | _ Set | Oro | | oronary r | ircery D. | Locabe | Ons | set and Death | |
| Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | | | | | _ | | |
| -5- | al Examiner | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | | | | | | | |
| executed an and irial-transit | | cause. Enter Underlying Cause (Disease or injury that initiated events C. | | | | | | | | | |
| be exe sician a burial- | | resulting in death) Last Due to (or as a consequence of): | | | | | | | | | |
| ficate g phys as the | Physician/Medica | | d | | | | | | | | |
| h certi tendin or use | ian/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome | of pregnancy 2 Fetal death | B Ectopic pregna | ncy | | 23d. Date | e of delivery | | |
| the at | ıysic | 1 Yes 2 No 9 Unknown | 4 ☐ Pregnant a 9 ☐ Unknown | t time of death | Other (specify) | FICATION | | Mon | tri Day | Teal | |
| that the ned by a detail | <u></u> | Part II. Other significant condition | ns contributing to death b | out not resulting in th | e underlying cause g | given in Part P | 23e, Did te | eco use contri | bute to the ca | use of death? | |
| quires en sig ould b | | 23b. Was decedent pregnant in the past 12 months? 1 | λ , Complica | tions of | Fa11 | | THE EXAMINE | 2 No | 3 Probably | y 4 Unknown | |
| law re has be le 2 sh | Completed | | | | | | 24a. Was a autop | an 24b. W | lere autopsy fi rior to comple | indings available etion of cause of | |
| n: The ficate or, pag | | 25, Was case referred to medical | | | 26 | Plans of Dooth (Cha | 1 Yes | med ² d 2 No 1 | Yes 24 | No | |
| ysicia is certi directe | Certificate: To Be | examiner? 1 X Yes 2 No | Hospital: | ent 2 🗆 ER/Outpa | _ 0 | Place of Death (Che her: 4 Nursing F | lome 5 Resid | ence 6 🗆 Other | r (Specify) | ⊘ | |
| ing Ph kiter th uneral | | 27. Manner of Death Tanatural 5 Pending | 28a. Date of injui (Month, Day | v, <i>Year</i>) injur | / wo | ıry at rk? | 28d. Describe h | ow injury occurre | | | |
| Attend death ctor: A | | 2 Accident Investigation 1 Investigation 2 Investigation 2 Investigation 2 Investigation 1 Investigation 2 Inv | not be 28e Place of Init | | | Yes 2 X No | Fall fr | | r or Rural Rou | ite Number | |
| al or A | | 4 LI Homicide determin | 4 Homicide determined determined building, etc. (Specify) hospital | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 100 E. Carroll St., Salisbury, MD | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director. | Medical | | Physician: To the best of xaminer: On the basis of ex | | | | | | | and manner stated. | |
| o the vithin 2 or the comple | Ň | only one) 3 Certifying 29b. Signature and title of certifier | Nurse Practitioner: To the | e best of my knowled | 7 | t the time, date and p se number | | ne cause(s) and ma 29d. Date signed | | | |
| | | D 4/1/1 |) | mO | 1 | 54127 | | 02/ | 20 / | 12012 | |
| 2 | | 30. Name and address of person w | 1 | | | | 100 0 | 2 | , | | |
| Stat | · A | 31. Date filed (Month, PanyYean) | 32. Registra | ar's Sanature | | lisbury | mo | 21800 | <u> </u> | - | |
| Registra | | LED 2 2 201 | - Denenge | ar's Signature | te d | V | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Feb (Wazy 7:180 M Ida M. Adams 2012 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death **Examiner** 4b. City. Town SINAT BAltimore TOSPILA Ba I timoire OT N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day, Year) **Director** 1 □ M 2 Ϊ F 247-74-3707 73 SC Oct 12, 1938 Usual Residence of Decedent 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 XYes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 900 Stoddard Court 21201 U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian er than "natural", or iter the Medical Examiner Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 🗶 No 5-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **Domestic Private Homes** Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file, and Mental H 2 Ada B. Nettles permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida D Adams 1105 East Chase. Street Baltimore, MD 21202 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) Feb 18, 2012 Lansdowne, Maryland Mt. Zion Cemetery 22. Name and Address of Facility Signature Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final therosc lezotic HEART Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner Due to (or as a donsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner: 2 🕱 🗓 Other မြ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D0054228 february ompleted cause of death (Item 23a) (Type, Print) address of person SINAI HOSPITAL 75 216 25216 31. Date filed (Month, Day, Year) **State** FEB 2 2 2012

DHMH 17 Rev 06-2011

Registrar

AMI

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J

| | No. |
|----------------|---|
| KENNETH BITTER | Division of Vital Records, P.O. Box 68760 |

| Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. | | | | | | | | | | | | |
|--|--|---|---|--|----------------|--|---|--|--|---|--|--|
| | | State of Maryland / Department of Health and 1 - State Registrar Certificate of Death | | | | | | Mental Hygiene Reg. No. 2012 04932 | | | | |
| | | Registrar 1. Decedent's Name (First, Middle, Last) | | | | ntinoato or b | - Gatri | 2. Date of Deat | h | \(\(\) | 3. Time of Death | |
| | Physicia Medio | | KENNETH DUFF BITTER | | | | | February 17, 2012 7:07 PM | | | | |
| | Examin | er | 4a. Facility Name (if not institution, give stre STELLA MARIS HOS | | | 4b. City, Town, or Timoni | Location of Death | 4c. County of Death Baltimore County | | | County | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda | | | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth 9. Birthplace (St (Month, Day, Year) Country) | | | ace (State or Foreign | |
| | Director | | 220-20-8580 1 M 2 □ F 84 Yrs Usual Residence of Decedent | | | | | Sept 16 | , 1927 | | | |
| | nyland a-f sho ied at | Director | 10a. State 10b. County Maryland Baltimore | | ty, Town or L | Millers | | | | 10 | 0d. Inside City Limits 1 ☐ Yes 2 🌠 No | |
| | the Ma or 28a se notif | | 10e. Street and Number | | | 10f. Zip Code | | 1 | 10g. Citizen of | | | |
| | th with ms 23a must k | Funeral | 3400 Clipper Mill | 21102 | | | No- 14. Race - American Indian, | | | | | |
| 9036 | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by | 11. Marital Status 1 □ Never Married 2 🔀 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No 45 - 146 14. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer If Yes, Give Year or Dates. | | | | | Specify: White | | | tc. | |
| 15-(| 72 hou n "natı Aedica | Completed | 15. Decedent's Educ (Specify only highest grade | completed) | (Give | edent's Usual Occupa e kind of work done d DO NOT use retired) | ation luring most of work | ing | 16b. Kind of B | usiness/Ind | ustry | |
| 212 | within ygiene. | | Elementary/Secondary (0-12) | College (1-4 or 5+) | | Engineer | | | | | e Industry | |
| Baltimore, Maryland 21215-0036 | should be filed n and Mental Hy 7 is marked oth raumatic event | To Be | Kenneth Oscar Bitter Mildr | | | | | | | | | |
| Mai | 12 short | | 19a. Informant's Name/Relationship (Type, Mrs. Anne L. Bitter | | | ling Address (Street a | | | | | | |
| ore, | int of Heali t: If item 2 | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re | moval from State | cemetery, cri | position (Name of ematory or other place | e) | | 20c. Location | • | | |
| Iţim | t. Pa ntme rtam njury | | 4 Donation 5 Other (Specify) | Du. | | ey Mem Gro | 4 - 100 | | rimoniu | | ryland | |
| 6500 York Road, Baltimore, Mar | | | | | | Maryl. | and $\frac{1}{2}$ | 1212 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | est, | | Approximate Interval Between Onset and Death | | | |
| Immediate Cause (Final disease or condition resulting in death) END STAGE LUNG DISEASE | | | | | | | | | | | | |
| | Examiner | er | Sequentially list conditions, b. | Post Comment | | | | | | | | |
| X | uted d ansit | amin | Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Co. Due to (or as a consequence of): | | | | | | | | | |
| | e executec cian and ourial-trans | 1 1 | | | | | | | | | | |
| 200 | cate be physic to the b | ledic | d. | | | | | | | | | |
| Box 68760 | requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit | Physician/Medica | FFEMALE: 23c. If yes, outcome of pregnancy 1 | | | | | | | 23d. Date of delivery Month Day Year | | |
| P.O. | at the ed by the detach | | 9 ☐ Unknown Part II. Other significant conditions conti | | sulting in the | underlying cause giv | en in Part I. | 23e. Did tol | pacco use conf | ribute to the | e cause of death? | |
| ds, F | quires then significant the significant period of the significant period of the significant th | ed by | | | | | | 1 🗆 Y | es 2 🗆 No | 3 🏻 Prob | ably 4 Unknown | |
| Division of Vital Records, | law has je 2 | Completed | | | | | | 24a. Was a autops perfor 1 Yes | sy med? | | sy findings available npletion of cause of 2 No | |
| ital | | Be | 25. Was case referred to medical examiner? | spital: | | Othe | ace of Death (Chec | k only one) | | | HOUDTON | |
| of V | <u>5</u> | e: To | 1 L Inpatient 2 L ER/Outpatient 3 L DOA 4 Nursing 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at | | | | | ome 5 Residence 6 Nother (Specify) HOSPICE 28d. Describe how injury occurred | | | | |
| onoi | tending leath. tor: Aft the fur | Certificate: | 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be | | | Yes 2 No | | | | | | |
| Divis | Hospital or Atten 24 hours after deat Funeral Director: etely filled in by the | | 4 Homicide determined | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Medical | (Check 2 Medical Examine) | an: To the best of my knower: On the basis of examination of the basis of examination of the basis of the bas | on and/or inve | estigation, in my opinio | on, death occurred a | t the time, date an | id place, and du | e to the cau | se(s) and manner stated. | |
| | To the I within 2 To the I complete | | 29b, Signature and title of certific | 2 CANP | | 29c. License | 99797 | | 29d. Date signe 2/2/2 | d (Month, D | lay, Year) | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 | | | | | | | | | | | |
| State 31 PER 31/2 (2012ar) 32. Reputrar's Instruction (1997) 32. Reputrar' | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clair William Bressler, Jr. 10:00 AM February 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Perr Point CPCI If Under 1 Year If Under 2 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day 1945 1 XM 2 □ F Months Hours 215-40-9645 **Director** 66 Pennsylvania Jsual Residence of Decedent 10a. State 10b. County death with the Maryland 10c. City. Town or Location tems 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Marvland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 612 Middlesex Road 21221 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 🔀 Married ō δ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Operations Manager Tour Bus Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clair William Bressler, Sr. Shirley Fabian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Debra Ross-Bressler/Wife Middlesex Rd., Essex, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Metro Crematory Inc. 02/20/2012 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Euneral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ₽nysician/ disease or condition resulting in death) eh nknown Medical to (or as a consequence of) Examiner Server dially list conditions if any, leading to immediate cause. Enter Underlying Exami burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ၉ 1 Nonetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. • Funeral Director: After this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 040723

State Registrar

Bressler,

Maryland Health Care

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 10b, per fb, g924 2-22-12 sm
State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BOOKER Medical 30 AM 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CITY HANSON 754 BAUTIMORE 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 ☑ M 2 ☐ F Days Months Hours Min. Director 251-16-8 1838 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 93a or 98a.4 show 10a. State 10b. County event, the Medical Examiner must be notified at **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Tes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1603 STREET or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 1 ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black. White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Specify: BUACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) MERCHANT MERCHANT MATINES EAMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ UNKNOWN LIROUNER MAE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUCHAL 1REIDA A JUL E. BALTIMOXE 57 injury or other 10-216E 12 5,00,2 9-Troust 下的包以证 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) CARMEL 4 Donation 5 Other (Specify) BALTIMORE, MD 2.22.12 21. Signature of Euneral Service Licensee any in 22. Name and Address of Facility DESC HUDSWIDT - 1 homes Skarda Funeral Home BAUTIAURE, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Cardiac arryhemias Medical HR Due to (or as a consequence of): Examiner therus clerotic heart clisease Sequentially list conditions, if any local state that cause. Enter Underlying Cause (Disease or iinjury 5425 Examiner Due to (or as a consequence on the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ils certificate has been signed by the attendin director, page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Blindness Drusati'e Benign Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has the content of autopsy the Hospital or Attending Physician: The performed 1 Yes 2 Wo 2 D N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 101 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36494 K DUSHIMO 2-13-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DESAIMO 716 maidenchaice lane Balamore mis ville 32. Receirar's Service State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February 2012 7:00 P M Ernestine Boyle Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 1515 Pickford Lane Bowie Social Security Number 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🕅 F Months Days Hours Min. (Month, Day, Year) Director 1928 Sommerville, TN 413-64-3892 83 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Directo TN 1 Yes 2 □ No Shelby Memphis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1714 Orr 38108 U.S.A. within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 ☐ Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) House Keeping Home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Trannie Morrow Shaw Artie Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Boyle 4750 St. Elmo, Memphis, TN 38128 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State AntTock of Bapt 1 ster place) Church Cemetery 1 Durial 2 Cremation 3 Removal from State 2/23/2012 4 ☐ Donation \$ ☐ Other (Specify) Whitesville, TN 22 Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ cancer Una Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🗓 No Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2 4 No 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Daughter's Hospital: 1 ☐ Yes 2 🗓 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature and title of certilie

Tuppeman MO

Box 68760

Records, P.O.

Division of Vital

Registrar DHMH 17 Rev 7/2009 completed cause of death (Item 23a) (Type, Print

9200 BASIL CT 32. Registrar Signatue

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

LARGO

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1)25001

02-16-2012

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Appeartment of Health and Mental Hygiene

| | | | 1-State of Maryland State of Maryland Registrar | 1/Depa 2/15/2 Cer | ertment of He 2012dhb tificate of De | ealth and I eath | Mental Hy | giene Reg. No.201 | 2 04938 | 6 |
|----------------------------|---|--------------------------|--|----------------------------|--|-----------------------------|---|--|--|----------|
| | | | Decedent's Name (First, Middle, Last) | | | | 2. Date of Dea | ath | 3. Time of Death | |
| | Physicia Medio | | TRACIE M. BYNUM | | | | JANUAR | $\mathbf{Y} \stackrel{Day}{3} 1 20$ | 12 3:20 P M | 1 |
| | Examin | | 4a. Facility Name (if not institution, give street and number) | | 4b. City, Town, or L | | | 4c. County of | | |
| | 3.13 | | ST. THOMAS MORE NURSING HOME 5. Social Security Number 16. Sex 17. Age (In vrs. Ins. | | HYATTS | | | | GEORGE'S | |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 □ M 2 🛣 F 7. Age (In yrs. last 1 □ M 2 🛣 F 40 | Yrs. | Months Days | Hours Min. | 8. Date of Birt (Month, Day OCT • 9 | | D. Birthplace (State or Foreign Country) ASHINGTON, DC | 7 |
| | | | Usual Residence of Decedent | | | . | 1001. 9 | | ADITINGTON, DC | |
| | yland •f sho ed at | Director | 10a. State 10b. County 10c. City, | Town or Loc | cation | | | | 10d. Inside City Limits | 1 |
| | e Mar r 28a notifi | Dire | MD PRINCE GEORGE'S UPP | ER MA | RLBORO 10f. Zip Code | | | | 1 X Yes 2 □ No | 0 |
| | /ith th | ral | 710 NEW ORCHARD PLACE | | 20774 | | | 10g. Citizen of What USA | it Gountry? | |
| | eath v | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. | 13. V | Vas Decedent of Hisp | panic Origin? (Sp | ecify Yes or No- | | American Indian, | - |
| ဖွ | fter de | by | 1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give | | Yes, specify Cuban, | | Rican, etc.) | Black, ' | White, etc. | |
| Ö | within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at | Completed | Year or Dates. | | ☐ Yes 2X☐ No | | | Specify: B | LACK | _ |
| 7 | 72 hd In "na Medio | nple | (Specify only highest grade completed) | (Give F | lent's Usual Occupati kind of work done dur O NOT use retired) | ion ring most of work | <i>tin</i> g | 16b. Kind of Busin | less Industry | |
| 212 | within giene. er tha the I | | Elementary/Seconday (0-12) College (1-4 or 5+) 3 yrs | | IAL WORKE | R | | GOVERNM | ENT | |
| nd | e filed within 72 hours after death with the Maryland that Hygiene. An Hygiene dether than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | To Be | 17. Father's Name (First, Middle, Last) | | 1 | | | Maiden Sumame) | | |
| Уa | should be file n and Mental I 7 is marked o raumatic eve | ř | MELVIN MARTIN | | | DEBOR | RAH A. B | RISCOE | | |
| | ~ ± 6 ± | | 19a. Informant's Name/Relationship (Type, Print) DEBORAH A. MARTIN/DGT. | 19b. Mailin 710 | g Address (Street and NEW ORCHA) | d Number or Rur RD PLACE | al Route Number UPPER | ; City or Town, State MARLBORO , | e, Zip Code) MARYLAND 2077 | 74 |
| re, | of Heal of Heal fitem | ij | | ce of Dispos | sition (Name of | | Date | 20c. Location - Cir | ty or Town, State | - |
| Ē | Page ment c tant: If | - 3 | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State WASH | INGTO | natory or other place) N NAT L C | EME 2/6/ | 2012 | SUITLAND | ,MARYLAND | |
| Baltimore, | permit. Page 1 Department of Important: If i any injury or o | | 21. Signature of Funeral Service Licensee | | | | | | RAL HOME, INC. YLAND 20785 | |
| н | | | 23a. Part / Enter the disease, or complications that caused the death. shock or head failure. List only one cause on each line. | | | | | | Approximate | |
| m, | h, sician/ | 60 Y2 | Immediate Cause (Final disease or condition MULTIPLE SC | TEDAG | TC | | | | Interval Between Onset and Death | |
| | Medical Examiner | | resulting in death) a. Due to (or as a consequent of the consequ | | 10 | | | | | |
| | | Jer | Sequentially list conditions, if any, leading to immediate Due to (or as a consequer | nce off: | | | | | | 4 |
| | uted d ansit | Examiner | if any, leading to immediate Cause (Disease or iinjury that initiated events Due to (or as a consequence) | | | | 1 11 | WEDICAL EXAMINER | | |
| | exectian an | Ĕ | resulting in death) Last Due to (or as a consequer | nce of): | | | APPROVED B | Men | | |
| 9 | certificate be executed nding physician and use as the burial-transit | edical | d | | | CERTIFICA | | MEDICAL EXAMINER | _ | _ |
| 89 | ding propertifications in the properties of the | Ž/ | IF FEMALE: 23c. If yes, outcome of pregnance 23c. If yes, outcome 35c. If yes | ·y | | | | | | |
| Box | death o | icia | in the past 12 months? | | Ectopic pregnancy Other (specify) | | | 23d. Date of Month | * | |
| | t the d by the tacher | Phys | 1 Yes 2 No 4 Pregnant at time of dea 9 Unknown 9 Unknown | | _ | | | | | \dashv |
| ກຸ. ກຸ | law requires that the death certific has been signed by the attending in 2 2 should be detached for use as | Completed by Physician/M | Part II. Other significant conditions contributing to death but not result RESPIRATORY FAILURE VENTILATOR | _ | | in Part I. | | | te to the cause of death? Probably 4 Unknown | n |
| Division of Vital Records, | aw requas beer 2 shou | plete | QUADRIPLEGIA | | | | 24a. Was a | | e autopsy findings available r to completion of cause of | \dashv |
| Ř | cate h | | SEIZURE DISORDER | | | | perfor | med? dear | th? Yes 2 No | |
| <u>a</u> | ician certifi rector | m i | 25. Was case referred to medical examiner? | | Other | e of Death (Chec | k only one) | | | - |
| <u></u> | y Phys arthis eral di | 은 - | | R/Outpatien Bb. Time of | 28c, Injury a | | | ence 6 Other (Sow injury occurred | ipecify) | \dashv |
| - 0 | ath. rr. Afte | icat | 1 ☑XNatural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident ☐ Investigation | injury | work? | s 2 🗆 No | | - Injury cocurred | | |
| <u> S</u> ≥ | or Attending Physician: The law after death. Director: After this certificate has in by the funeral director, page 2 in | Certificate: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify) | e, farm, stre | et, factory, office | | 28f. Location (Si City or Town | | r Rural Route Number, | |
| <u> </u> | spital | | 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowled | ge, death o | ccured at the time, da | ate and place, ar | nd due to the cau | se(s) and manner a | s stated. | \dashv |
| : | Io the Hospital or Attending Physician: The within the within the Hospital or Attending the Euneral Director. After this certificate I completed filled in by the funeral director, page | Medical | (Check 2 Medical Examiner: On the basis of examination at only one) 3 Certifying Nurse Practioner: To the best of my ki | nd/or investi | gation, in my opinion, | death occurred a | t the time, date ar | nd place, and due to | the cause(s) and manner state | ed. |
| | 2 4 × 5 | | 29b. Signature and fittel of certifier | 0 | 29c. License nu | umber SSSS | _ | 29d. Date signed (M | | |
| | | | 30. Name and address of person who completed cause of death (Item 2) | Ba) (Type P | | 7 0 | | restury | 62012 | \dashv |
| | | | PAUL DEVORE MD 4203 QUEENSBURY | ROAD | HYATTSVIL | LE,MARY | LAND 207 | 81 | 3 | |
| | Stat Registra | | 31. Date filed (Month, Day, Year) FEB 1 6 2012 32. Registrar's Signature | · hon | . 1.1 | | | | | |

DHMH 17 Rev 7/2009

| | | | For State | | State of | Marylar | - | artment of I | | and M | ental Hyg | giene | 12 | 01.0 | 27 |
|----------------------------|--|--------------|--|---|--|--|---|---|----------------------|-----------------|-----------------------------------|-------------------|---|------------------------------|-------------------|
| | _ | | Registrar | 18: - 1 - 1 1 | | | Cer | tificate of L | Death | | | Reg. No. | 112 | U 4 3 |)) / |
| ı | Physicia Medic | | Decedent's Name (First, | Middle, Last | Patri | cia Ar | nn Ber | nacki | | | 2. Date of Dea Month Februa | | 2012 | 3. Time of 1 9:39 | A M |
| many. | Examin | | 4a. Facility Name (if not ins 1616 Hollir | | | ier) | | 4b. City, Town, o | r Location of ppa | Death | | | ty of Death Tarfor | d | 11 |
| # | Funeral Director | | 5. Social Security Number 219–38–4482 | 6. Se | х 7 Пм 2 Х F | . Age (In yrs. I | | If Under 1 Year Months Days | If Under 24 Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day | Year) | Count | | Foreign |
| | and show at | 'n | Usual Residence of Dece 10a. State 10b. 0 | | Λ. | | y, Town or Loc | ation | | | NOV 12 | , 1942 | Mary | Land Od. Inside City | y Limits |
| | Maryla 28a-f | Director | MD | Harfo | rd | İ | | Jopp | a | | | | | 1 🗆 Yes | 2 X No |
| | h the | | 10e. Street and Number | | | | | 10f. Zip Code | | | | 10g. Citizen of | What Coun | ry? | |
| | ms 23 must | Funeral | 1616 Hollir | ngswort | | | | | 1085 | 0.10 | 25.34 | | USA | | |
| 920 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. | by | 11. Marital Status1 Never Married 23 Widowed 4 Di | | 12. Was Deced Armed Ford 1 Yes If Yes, Give Year or Date | es? 2 🔀 No | If | Vas Decedent of H Yes, specify Cuba ☐ Yes 2 XNo | n, Mexican, | Puerto P | iry Yes or No- lican, etc.) | | ice - America ack, White, e ^{fy:} Whit | tc. | |
| 2-0 | 'natur | olete | | ecedent's Ed | | | | ent's Usual Occup | | of workin | _ | 16b. Kind of | | | |
| 21215-0036 | within 72 giene. er than ' the Me | Completed | Elementary/Secondary | | College (1-4 | or 5+) | life. DO | ind of work done of NOT use retired) hone Ope | | OI WOIKIII | 9 | Hosi | oital | | |
| pu | filed tal Hyg | o Be | 17. Father's Name (First, M | iddle, Last) | | | | | 18. Mother | | (First, Middle, I | | ne) | | |
| Maryland | should be file h and Mental H 7 is marked o traumatic eve | J D | William | | | 5 | Shaney | | | oroth | , | | | ck1y | |
| Ma | 12 shoulth and 27 is rau | | 19a. Informant's Name/Red Anthony M. I | | | nand | | g Address (Street : Hollings | | | | City or Town, | | | |
| ore, | of Hear | | 20a. Method of Disposition | | | 20b. F | Place of Dispos | sition (Name of eatory or other place | | | ate | 20c. Location | | | |
| Baltimore, | Page ment tant: It | | 1 Burial 2 XCrer 4 Donation 5 C | Other (Specify | | Met | ro Cre | natory, | Inc. 0 | | | | more, | | |
| Ball | permit Depart Import any inj | | 21. Signature of Funeral Se | ervice License | • George | e MacNa | | Name and Addres | | | | Society timore | | D, Inc 21228 | |
| П | | | 23a. Part 1. Enter the dise shock, or heart failure | ase, or comple. List only on | e cause on eacl | n line. | | r the mode of dyin | g, such as ca | ardiac or | respiratory arre | est, | | Approximate Interval Betw | reen |
| in a | Physician/ Medical | | Immediate Cause (Final disease or condition resulting in death) | - | a | ical Ca | | | | | | | | Onset and D | eath |
| | Examiner | | | | Due to (o | r as a consequ | dende oi): | | | | | | | | |
| | n t | iner | Sequentially list conditions if any, leading to immediat cause. Enter Underlying | | Due to (or | as a consequ | uence of): | | | | | | | | |
| | ecuter and Il-trans | Examine | Cause (Disease or injury that initiated events resulting in death) Last | | Due to (or | as a consequ | uence of): | | | | | | | | |
| 09. | cate be executed physician and the burial-transit | dical | , | L | d | | , | | | | | | | | |
| 876 | tificate ng phy as th | Med | IF FEMALE: | | | | | · | | | | | | | |
| . Box 687 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Anou's after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi | Physician/Me | 23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 ☑ No g ☐ Unknown | THE T | | rth 2 🗀 Feta ant at time of d | al death 3 | Ectopic pregnand Other (specify) | ey . | | | | ate of delive onth | * | ear |
| ls, P.O. | uires that t n signed br uld be deta | by | Part II. Other significant c | onditions cor | ntributing to dea | ith but not res | ulting in the ur | nderlying cause giv | ven in Part I. | | | oacco use cor | | 1 | ath? nknown |
| corc | law require has been si ge 2 should | Completed | | | | | | | | | 24a. Was a | | Were autop | sy findings av | ailable use of |
| Re | ling Physician; The la n. After this certificate he funeral director, page | | <u></u> | | | | | | | | perform | med? | death? | _ | |
| /ita | sician; The certificate lirector, pag | o Be | 25. Was case referred to me examiner? 1 ☐ Yes 2 ▼ No | | ospital: | | FD/0 : " | Oth | ace of Death er: | | - | | | | |
| of | ig Phys ter this neral d | te: To | 27. Manner of Death | | 28a. Date of | | ER/Outpatient 28b. Time of injury | 28c. Injury work | / at | | ne 5 Reside 3d. Describe ho | | | | |
| ion | l or Attending after death. Director: After I in by the fune | Certificate: | 2 Accident | Pending nvestigation Could not be | | | | M 1 🗋 | Yes 2 N | No. | | | | | |
| Division of Vital Records, | tal or Atressive all Directors | | | determined | | f Injury - At ho , etc. <i>(Specify</i> | | et, factory, office | | 2 | 8f. Location (St. City or Town | | oer or Rural F | Route Numbe | r, |
| ; | To the Hospital or within 24 hours afte To the Funeral Dirucompletely filled in | Medical | (Check 2 L Me | dical Examin | er: On the basis | of examination | n and/or investi | ocurred at the time gation, in my opinion death occurred at t | n, death occu | urred at tl | ne time, date an | d place, and di | ue to the caus | se(s) and manı | ner stated. |
| 1 | To the within 2 To the comple | | 29b. Signature and title of | | 1 | | | 29c. License | | | | 9d. Date signe | | | |
| D | | | · Q | MAG | en_ | | | D0069 | 631 | | | Februai | cy 21, | 2012 | |
| | 61 | | 30. Name and address of p Amanda Nick | | | , | , , , , , | ^{int)} Charles | St S | Suite | e 306 ' | Towson. | MD | 21204 | |
| | Stat Registra | e ar | FEB 2 2 2012 | Jense Sense | 32. Re | istrar's Signat | | | , | | | | | | |

| | | | State of Maryland / | | artment of H | | | 21 | 112 | 04938 |
|--|--|------------------|---|------------------|---|------------------------------------|--------------------------------------|--------------------------|------------------------|---------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | uncate of L | Calli | 2. Date of De | Reg. No | , , , , | 3. Time of Death |
| | Physicia | | Paul D. Betz,Sr. | | | | Februa | | Year 2012 | 16:72 PM |
| | Medic Examin | | 4a. Facility Name (if not institution, give street and number) | | 4b. City, Town, or | Location of Dea | | 7 | y of Death | |
| | | | Season's Hospice | | Randal1 | stown | | Balti | | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last bit | thday) | If Under 1 Year Months Days | If Under 24 Hrs Hours Min | | h | | lace (State or Foreign |
| | Director | | 212-30-6045 1 ₹ M 2 □ F 79 Usual Residence of Decedent | Yrs. | | | Jan. 3, | | Mary1 | ** |
| pu | show | ě | 10a. State 10b. County 10c. City, Tow | n or Loc | cation | | | | 1 | Od. Inside City Limits |
| Aaryla | 8a-f a | rect | Maryland Baltimore Arbut | | | | | | | 1 ☐ Yes 2 😾 No |
| the | 1 or 2 3e no | ٥ | 10e. Street and Number | us | 10f. Zip Code | | | 10g. Citizen of | What Count | |
| ı with | is 23a nust l | Funeral Director | 1343 Poplar Ave. | | 21227 | | | United | State | S |
| death | r item ner n | E. | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? | 13. V | Vas Decedent of His f Yes, specify Cubar | spanic Origin? (S | pecify Yes or No- to Rican, etc.) | | ce - America | |
| 36 after | al", ol | d by | 1 Never Married 2 Married 1 Types 2 No If Yes, Give | 1 | ☐ Yes 2 🛣 No | Specify: | | Specif | LTh | ite |
| | atura ical E | Completed | 15. Decedent's Education 16 | . Deced | lent's Usual Occupa | ation | | 16b. Kind of E | | Linta |
| 215 | an "r Med | du | (Specify only highest grade completed) | (Give k | kind of work done di O NOT use retired) | uring most of wo | Ü | | | , |
| <u>K</u> | giene ner th t, the | | Elementary/Secondary (0-12) College (1-4 or 5+) | Bus | Driver | | | Transpo | rtati | on |
| | ital H ed otl | To Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Na | me (First, Middle, | Maiden Surnam | ne) | |
| 5 | and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at | | John C. Betz,Sr. | | | | R. Hackm | | | |
| Ma 2 sho | of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | | 0 / | | g Address (Street a | | | | | |
| a nd and | Health tem 27 other tra | | 20a. Method of Disposition 20b. Place 6 | | grovehill sition (Name of | Road,A | rbutus,M | aryland 20c. Location | | |
| Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after | | | 1 Burial 2 Cremation 3 Removal from State cemete | ery, crem | natory`or other place | ´ ; | | Glen Bu | rnie, | Maryland |
| | Department of Important: If any injury or once. | | 21. Signature of useral Service Licensee | 22 22 | Crematory Name and Address | s of Facility AM | 23.2012 | ATERDAT II | 01/17 71 | |
| m e | Depar Impo any ir once. | | Talm an Back | 13 | 28 Sulphu | AM Sprin | g Rd. Ar | NEKAL H | OME, II | NG. nd 21227 |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. | not ente | r the mode of dying | , such as cardia | or respiratory arr | est, | | Approximate Interval Between |
| | sician/ | | | 100 | 16- R | collect | Crup |) | 1. | Onset and Death |
| | Medical xaminer | | Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence Sequentially list conditions, | of): | | | | _ | | Yerrs |
| | | e. | Sequentially list conditions, E. Kherosch. | ture | Te (an | 130 WA | 11 (4) /4. | A) 110 | re | |
| pa | ısit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 01): | | | | | | |
| xecut | al-trai | Еха | that initiated events c. Due to (or as a consequence | of): | | | | | + | |
| certificate be executed | ohysician and the burial-transit | dical | d | | | | | | | |
| 876 ifficate | ng phys as the | Med | IF FEMALE: | | | | | | | |
| x 68 h certifi | tendir or use | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat | h 3 🗆 | Ectopic pregnancy | / | | 23d. Da | ate of deliver | У |
| Box | the at hed fo | /sici | 1 Yes 2 Two 4 Pregnant at time of death 9 Unknown 9 Unknown | | Other (specify) | | | Mo | onth [| Day Year |
| H.O. | | | Part II. Other significant conditions contributing to death but not resulting | in the ur | nderlying cause give | en in Part I | 230 Did to | hacea usa cont | ributo to the | cause of death? |
| | signe d be c | d by | 3 | | , | | | | | ably 4 Unknown |
| cords, law requires | been | lete | | | | | 24a. Was a | | | sy findings available |
| HeC The law | ate has page 2 s | Completed | | _ | | | autop | sy med? | prior to com death? | pletion of cause of |
| E | tificat tor, pa | | 25. Was case referred to medical | - | 26. Pla | ce of Death (Che | 1 \(\superset \text{Yes}\) | 2, No | 1 Yes 2 | No |
| Vital Kecords, sysician: The law requires | is cer direc | 1 B | examiner? 1 Yes 2 No | utpatient | Othor | | | ence 6 Oth | er (Specify) | InP+ Hospik |
| DIVISION OF tal or Attending Ph | after death. Director: After this certificate I in by the funeral director, pag | | 27. Manner of Death 28a. Date of injury 28b. | Time of njury | 28c. Injury work? | at | 28d. Describe ho | | | 717 1707 |
| tendii D | the fu | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be | | | ∕es 2 □ No | | | | |
| or At | after of Direct | l G | 4 Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify) | ırm, stre | et, factory, office | | 28f. Location (S: City or Town | | er or Rural F | Route Number, |
| Spital | nours neral / filled | cal | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, | death or | courred at the time | date and place | and due to the car | see(e) and man | nor an etator | |
| To the Hospital or Attending Physician: | within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director, | Medical | (Check only one) 3 Certifying Nurse Practitioner: To the best of my know kno | or investi | gation, in my opinion | death occurred | at the time date an | d place and du | e to the caus | e(s) and manner stated |
| To th | within comp | — r | 29b. Signature and title of certifier | | 29c. License | number | 1 | 9d Date signe | d (Month De | v Vear |
| | | | 1 Van D | | D | 740 | 13 | Feb- | - ve, 2 | -1,2012 |
| N A | , | | 30. Name and address of person who completed cause of death (Item 23a) (| Type, Pr | rint) | 1 | 7. | | | 5/ |
| 7 | | | 31 Date filed (Month Day Your) | 0 | 474 H | wat | 16. 151 | cd 7 | 2100 | 5/ |
| | State Registra | e Ir | 31. Date filed (Month Pay, Year) 2012 2. Registrar's Signature | back | les | | | | | |
| | | | Monday las | | | | | | | |

| | | For State Registrar | State of N | Maryland , | | artmer <i>tificat</i> | | | and M | lental Hygid | ene 3. No. 20 | 12 | 04939 |
|--|------------------|--|--|----------------------------------|-------------------|----------------------------|--|------------------------------|------------------|--|----------------------------|---------------------------|--|
| Physic Med | | 1. Decedent's Name (First, Mida | Edward \ | W. Beni | ak | | | | | 2. Date of Death | 18 ^y 2012 | Year | 3. Time of Death 2:00 P M |
| Exami | | 4a. Facility Name (if not institutio | n, give street and number, 1 Macalpine Rd. |) | | 4b. City, | Town, or | Location of Ellicot | | | 4c. County | | ward |
| Funera Director | | 5. Social Security Number 192-18-1460 Usual Residence of Decedent | 6. Sex 7. A | Age (In yrs. last b 89 | oirthday) Yrs. | If Unde Months | r 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day, Yo Dec 29, | 1922 | 9. Birthp Coun | place (State or Foreign try) |
| Maryland 28a-f shov otified at | Director | 10a. State 10b. Count | Howard | 10c. City, To | own or Loc | cation | | Ellicot | tt City | | · · · · · · · | 1 | 0d. Inside City Limits 1 ☐ Yes 2 🏝 No |
| s 23a or 3 | Funeral D | 10e. Street and Number 3901 Macalpine Rd | l. | • | | 10f. Zip | Code | 210 | 42 | 10 | g. Citizen of W | hat Cour | |
| Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anoiee. | Completed by Fur | | If Van Cive | No WWI ERA | 1 5a. Deced | Yes, spec | 2 No 2 No al Occupa rk done d | n, Mexican Specify: | , Puerto I | cify Yes or No- Rican, etc.) | | k, White, 6 Whi | te |
| d within dividence. | Be Con | Elementary/Secondary (0-12) | College (1-4 or 5+ | r 5+) | life. DO | O NOT use | retired) | f Procu | | | Е | ngine | ering |
| ylanc | 면 면 | 17. Father's Name (First, Middle, | Walter Be | niak | | | | 18. Mothe | er's Name | (First, Middle, Mai | den Sumame, Mary |) | |
| hd 2 shoulealth and m 27 is not traum | ; | 19a. Informant's Name/Relations Eileen Beniak Sp | | 1: | | | | | | Route Number, City, MD 2104 | | ate, Zip C | Code) |
| Baltimore, oermit. Page 1 and Department of Hee Important; If item any injury or other once. | | 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (| (Specify) | 20b. Place ceme | St. Lou | natory or o | ther place etery | | Feb 2 | 23, 2012 | | sville, | wn, State Maryland |
| Departing the permit of the pe | | 21. Signature of Funeral Service | Schenbuh- | 1 Molag | 3 22. | Name S 1 | ack Fu 71 Old | neral Ho Columb | me, P oia Pik | .A. e Ellicott City | , MD 2104 | 3 | |
| Physician/ Medical Examiner | 1 | 23a. Part 1 Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) | a | ed the death. Done. | o not ente | A/ | e of dying | g, such as o | cardiac or | r respiratory arrest, | | | Approximate Interval Between Onset and Death |
| | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as | s a consequence | e of): | | | | | | | | |
| : 68760 certificate be executed nding physician and use as the burial-transit | dical Ex | that initiated events resulting in death) Last | Due to (or as | s a consequence | e of): | | | | | | | | |
| 68 certific nding use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown | 23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown | 2 Fetal dea | ath 3 🗌 | Ectopic p Other (sp | | ý | | | 23d. Date Mon | | ory Day Year |
| of the de de de de de de de de de de de de de | ted by P | Part II. Other significant conditi | ons contributing to death | but not resulting | g in the ur | nderlying c | ause give | en in Part I. | | | co use contril | | e cause of death? |
| Vital Records, vsician: The law requires is certificate has been sig | Completed by | 25. Was case referred to medical | | _ | | | | | | 24a. Was an autopsy performe | d? de | ere autoprior to coneath? | sy findings available inpletion of cause of |
| f Vital Physician: this certific al director, | : To Be | examiner? 1 Yes 2 No 27. Manner of Death | | tient 2 ER/C | | | Other | 4 ∐ Nur | sing Hon | ne 5 Residenc | e 6 🗆 Other | | |
| DIVISION Of tal or Attending Phrs after death. al Director: After the death in by the funeral | Certificate: | 1 Natural 5 Pendin 2 Accident Investi 3 Suicide 6 Could | gation not be | ay, Year) | . Time of injury | М | | at Yes 2 🔲 I | - 1 | 8d. Describe how i | njury occurred | <u> </u> | |
| DIVIS | | 4 ☐ Homicide determ | nined 28e. Place of In building, et | tc. (Specify) | | | | | | 8f. Location (Stree City or Town, S | tate) | | |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. | Medical | only one) 3 Certifying | g Physician: To the best of Examiner: On the basis of Nurse Practitioner: To the | examination and | or investi | gation, in n death occu | ny opinior irred at th | n, death occ e time, date | curred at t | he time date and n | lace and due: | to the caus | se(s) and manner stated |
| Viith Viith | | 29b. Signature and tith of certified | tell | <u> </u> | NN | 29c. | License 3 | number 461 | 3 | 29d. | Date signed | (Month, D | ay, Year) 2012 |
| Dx, 1 | | 30. Name and address of person | who completed cause of a | death (Item 23a) | (Type, Pr | int) | Ba | OWA | Rd | Elkrid | ae M | 0 2 | 11075 |
| Sta Registr | | 31. Date file file the Day Year | 2 Sexen | rar's Signature | are | | | | | , , , , | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death Physician/ February 2012 12:05 AM Joseph Valentini Butta Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Raltimore 29 Bridle Lane Nottingham 5. Social Security Number 7. Age (In yrs. last birthday) f Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral Hours 1 XM 2 □ F 79 0870871932 Maryland 219-28-1162 Director Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location with the Maryland items 23a or 28a-f sho her must be notified at Director 10d. Inside City Limits 1 🗌 Yes 2 😾 No Maryland Baltimore Nottingham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other them." 29 Bridle Lane 21236 United States 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 ☐ No If Yes, Give Year or Dates. 1953–54 Black, White, etc. ð 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Divorced 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Forman Sheetmetal Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 Virginia Cherigo John L. Butta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Butta - Wife 29 Bridle Lane Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 02/22/2012 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 23 . P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. Lithonly one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence on: To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Director; Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated D0018406

State Registrar 31. Date filed (Month, Day, Yo

X DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2-20-2012

34 YORK Rd La Ther VIIIE Med 210

| | ase Type or Print in Black Indelible Ink. Ensure All Copies Are Legible | le |
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| | | | | For State | | State of | Marylan | | artmen rtificate | | | and M | - | _ | | 1.0 | 01. | 01.1 |
|-------------|--|--|---------------------|---|------------------------|---|---------------------------------------|---|-----------------------------|---------------------------|-----------------|------------|---|------------|---------------------|------------------------------------|-----------------------------|-----------------------|
| | | _ | | Registrar 1. Decedent's Name | e (First, Middle, | Last) | | <u> </u> | Timeate | OIL | eatri | | 2. Date of De | Reg. N | 0./ | 16 | 3. Time o | f Death |
| : | Alex | Physicia Medic | al | SUSAN | | DOROTHY give street and numb | | BLOC | | | | | FEBRUAR | Y | | Year | | 4 A M |
| | .) | Examin | er | | | OF BALTIM | | | 1 | | Location o | | | 4 | c. County N/A | of Death | | |
| | | Funeral | | 5. Social Security No | | | 7. Age (In yrs. la | ast birthday) | If Under | 1 Year | If Under | 24 Hrs. | 8. Date of Bir | | | | olace (State | or Foreign |
| | | Director | | 216-42-78 | | 1 □ M 2 🛱 F | | 67 Yrs. | Months | Days | Hours | Min. | (Month, Da | | - 1 | Coun | ny) NY | |
| 3 | | nd thow | 'n | Usual Residence of 10a. State | 10b. County | | | y, Town or Lo | ocation | | <u></u> | | 007007 | 101 | <u> </u> | T | Od. Inside C | ity Limits |
| BLOCK | | Aaryla 8a-f s tified | rect | MD | N/A | | ВА | LTIMO | RE | | | | | | | | 1 🔀 Ye | s 2 🗆 No |
| 20 | | the Na or 2 | | 10e. Street and Num | | | | | 10f. Zip | Code | | | | 10g. C | itizen of V | Vhat Cour | itry? | |
| DOROTHY | | hours after death with the Maryland natural", or items 23a or 28a-f sho lical Examiner must be notified at | by Funeral Director | 5905 HI | GHGATE | | | | _ | 215 | | | | | | | USA | |
| CO. | | r deat or iten niner i | y Fu | Marital Status Never Marri | ied 2 Marri | 12. Was Deced | es2 | | | | | | cify Yes or No- Rican, etc.) | | | e - Americ k, White, | an Indian, etc. | |
| 8 | 036 | s afte ral", c Exam | q pe | 3 Widowed | | ed 1 Yes : If Yes, Give Year or Date | | | 1 🗆 Yes | ≥ X No | Specify: | | | | Specify: | WHI | ΓE | |
| | 215-0036 | hour "natu | Be Completed | (Spe | 15. Decedent | t's Education at grade completed) | | 16a. Dece | edent's Usua kind of wor | l Occupa | ation | t of worki | na | 16b. | Kind of Bu | siness/In | dustry | |
| SUSAN | 121 | within 72 giene. er than " , the Mec | mo | Elementary/Seco | | College (1-4 | 1 or 5+) | life. L | OO NOT use | retired) | | COT WORKI | 19 | | 3.7 | TIDAT | 170 | |
| 505 | | ed wir Hygie other ent, th | Be C | 17. Father's Name (F | First. Middle. La | ast) | | | טם | UKKE | EPER 18 Moth | er's Name | e (First, Middle, | Maiden | | | NG HOI | 1 <u>E</u> |
| 1 | aryland | l be fil lental rked ric ev | မ | JACK | | , |] | BLOCK | | | CLA | | , | | | SIME | L | |
| 3, | lary | should and M is mar | | 19a. Informant's Na | me/Relationshi | ip (Type, Print) | | 19b. Mail | ing Address | (Street a | nd Numbe | er or Rura | l Route Numbe | er, City o | r Town, S | tate, Zip (| Code) | |
| 3 | <u>√</u> | 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. The area and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | | CLARA B | | MOTHER | | | | | LANE, | | 6, BAL | | | | | |
| i kneuch as | Baltimore, | ge 1 a nt of H : If ite or oth | | | Cremation | 3 Removal from S | 20b. P State Δ R | Place of Displemetery, cre LINGT LZUK | osition (Nam matory or o | e of her place (FTF | Žv_ | | Date | | _ocation - | • | | |
| 12 | Itim | permit. Page 1: Department of I Important: If it any injury or of | | 4 ☐ Donation 21. Signature of Fur | | | l ĈĤ | IZÜK | AMUNO | CONG | e of Facilit | | 1/2012 | | BALTI | | | |
| afe | Ba | Depart Impo | И |) Signatur of the | 200 | - Indee | | | | | | | LEVIN ROAD, | | | | | 208 |
| - | | | | 23a. Part 1. Enter the | he disease, or o | complications that can ly one cause on eac | used the death | h. Do not ent | | | | | | | | 1 | Approxima Interval Be | te |
| - 2 | _P | h sician/ | | Immediate Cause (I disease or conditio | Final | | 167 CF | ANCEI | e n | 1774 | ME | TAS | MASES | | | | Onset and | |
| | mark | Medical Examiner | | resulting in death) | - | | r as a consequ | | | | | | | | | | | |
| | | | er | Sequentially list con | nditions, | b. — | r as a consequ | lence oti: | | | | | | | | | | |
| | | rted d ansit | Examiner | if any, leading to im cause. Enter Under Cause (Disease or i that initiated events | injury | 2 | , | | | | | | | | | | | |
| | | ie be executed iysician and ne burial-transit | Ĕ | resulting in death) L | | Due to (o | r as a consequ | ience of): | | | | | | | | | | |
| | _ | ate be ohysic the bu | dical | | | d | | | | | | | | | | | | |
| | 687 | ertifica ding p | × We | IF FEMALE: 23b. Was decedent | progrant | 23c. If yes, outco | ome of pregna | ncy | | | | | | | 22d Dat | e of delive | 271 | |
| | ×o | eath c atten d for u | iciar | in the past 12 r | nonths? | 1 Live B 4 Pregna | irth 2 🗌 Feta ant at time of c | ıl death 3 [| Ectopic p Other (sp | | у | | | | Moi | | Day | Year |
| | O. E. | requires that the death certificate is been signed by the attending phys should be detached for use as the | by Physician/Med | 9 🗌 Unknown | | 9 🗌 Unkno | | | _ | | | | | | | | | |
| | 9 . | ss that igned be de | by | Part II. Other signif | icant condition | ns contributing to dea | ath but not res | ulting in the | underlying o | ause give | en in Part | 1. | | - | | | ne cause of | |
| | rds | equire een si hould | eted | | | | | | | | | | 1 | | | | oably 4 🗆 | |
| | 000 | has b | Completed | | | | | | | | | | 24a. Was auto | | р | vere autop rior to co leath? | osy findings mpletion of | available cause of |
| | Œ i | in; The ifficate tor, pa | | 25. Was case referre | ed to medical | | | | | 26. Pla | ace of Deat | th (Check | 1 \(\text{Yes} | 201 | No 1 | ☐ Yes | 2 No | |
| | Vita | nysicia iis cert direct | To B | examiner? | JN6 | Hospital: | npatient 2 🗆 | ER/Outpatie | ent 3 🗆 DC | LOtho | arr. | | me 5 Resi | dence | 6 🗌 Othe | r (Specify |) | |
| | of | ng Ph fter th uneral | te: | 27. Manner of Death | 5 Pending | 28a. Date o | | 28b. Time o | | Bc. Injury work? | | 2 | 28d. Describe | how inju | ry occurre | d | | |
| | ion | ttendi death stor: A / the f | Certificate: | 2 Accident 3 Suicide | Investiga 6 Could n | ation | f laiva. At ha | f | M M | | Yes 2 🗌 | - | 005 11' # | 24 4 | | D | De la Mora | |
| | Division of Vital Records, P.O. Box 6876 | after after Direct | | 4 Homicide | determin | | of Injury - At ho g, etc. (Specify | | reet, factory | , onice | | | 28f. Location (City or Tov | | | r or Hurai | Houte Num | ber, |
| | ш, | To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. The Funeral Director; After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the | Medical | | | Physician: To the bearing of the basis | | | | | | | | | | | | anner stated |
| | | the H hin 24 the F mplete | | only one) 3 | ☐ Certifying | Nurse Practitioner: | | | e, death occu | irred at th | ne time, dat | | ce, and due to | the caus | e(s) and m | anner as | stated. | anner stateu. |
| | | 8 7 × 1 | | 29b. Signature and | 1 0 | IBBS | | | | ES C | | | | 29d. D | ate signed LUARY | (Month, 1 2012 | Jay, Year) | |
| - | | | | 30. Name and addre | ess of person w | ho completed cause | of death (Item | 23a) (Type, | Print\ | | | 1 | | . (1) | | | | |
| V | | | | RAJEE | | MA, MBBS | | AI HO | SPITA | L of | - BA | LTIMO | PRE | | | | | |
| , | | Stat Registra | • | 31. Date filed (Monti | 1, Day, rear) 1 2 2 20 | 12 2. Re | gistrar's Signat | Lar | Kel | | | | | | | | | |
| K | DHM | IH 17 Rev 06-2 | 011 | | | - | | 1 | | | | | | | | | | |
| 1 | | | | | | | | OPIGII | 1 4 1 4 | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Claire Marie Cartier 9:00 PM F<u>ebruary</u> 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1001 W. Joppa Rd. Towson Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Min 028-20-2528 Director 1 □ M 2 🔀 F 84 May 24, 1927 Massachusetts Usual Residence of Decede 28a-f show 10a. State notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Towson 1 ☐ Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be r Funeral 1001 W. Joppa Rd. 21204 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 2 X No Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thin any injury or other traumatic access. Mission Helpers Sacred Ht 5+ church ministry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Miranda Gilbert Arthur Joseph Cartier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204 Sr. Loretta Cornell, MHSH./pers rep 1001 W. Joppa Rd. Towson, MD Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory Feb. 23,2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mitchell-Wiedefeld Funeral Home, Inc. Raltimore, MD 21212 6500 York Rd. Baltimore. 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
World NTTHS Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE 23b. Was decedent preg 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 month Day Year Pregnant at time of death the g Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con bute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnods been Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: æ 25. Was case referred to Jedica 26. Place of Death (Check only one) Hospital 욘 1 Ye 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending atural injury work? iours after death.

neral Director: Aff
filled in by the fu 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide dermined City or Town, State within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse r: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated . Signature and title of certifier 29d. Date signed (Month, Day, Year)

2

State Registrar 30. Name and address of person

YORKRD.

LUTHERVI

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month $20\overset{\scriptscriptstyle{\mathrm{Ye}}}{1}\overset{\scriptscriptstyle{\mathrm{ar}}}{2}$ Eileen M. Cunningham February 7:45 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u> Gilchrist Center Howard County</u> Columbia Howard If Under 9. Birthplace (State or Foreign Country) District 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** Director 578-50-1027 1 □ M 2 💢 F 73 Usual Residence of Decedent Oct 9, 1938 Of Columbia 28a-f show 10a State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Laurel 1 Yes 2 XNo ms 23a or must be n 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9160-M Hitching Post Lane 20723 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. o. ş 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ traumatic Harold Cartwright Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other trau Kenneth M. Cunningham. 9160-M Hitching Post Lane Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 02/21/12 Baltimore, Maryland Signature of Funeral Service Licens Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ NEPHROSCIEROSIS disease or condition resulting in death) DIABETIC MONTHS Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical P.O. Box 68760 as IF FEMALE: ase 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death the Unknown by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, EMPHYSEMA 1 X Yes 2 No 3 Probably 4 Unknown Completed ISCHEMIC CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy bage performe STROKE ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: _ 2 💢 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify, this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 Yes 2 No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

6336

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD

D64395

CEDAR LANE COUMBIA, MS 21044

FEBRUARY 20, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend #18 per FH G924 2/28/2012 JH.
State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year May 0636A M atricia 2017 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital errol Carrol. 1esmineter Social Security Number Sex 8. Date of Birth (Month, Day, Nov • 27 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) Maryland 1 M 2 12 F Mir Director 215-32-6144 76 Nov. 1935 Usual Residence of Decedent show 10a. State 10b. County should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 924 Wampler Lane 21158 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hubbs ပ္ Chester Finn Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is Timothy Clarke 924 Wampler Lane Son Westminster, MD21158 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Carroll Cremation Set 2/20/12 Hampstead, Signature of Funeral Service License 22. Name and Address of Facility 22. Name and Address of Paclity 11824 Reisterstown Eline Funeral Home Reisterstown, MD les 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) vances Medical Due to (or as a consequence of): Disense_ Examiner Umonay Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-transi per capho and that initiated events resulting in death) Last Due to (r as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician Completed by Physician/Medical rul Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Pregnant a Month Day Year Pregnant at time of death Yes 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? director, page 2 should be Anemia, tuper podemia 2 No 3 Probably 4 Unknown 1 X Yes 24b. Were autopsy findings available prior to completion of cause of death? Steoporesis 24a, Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2200 Hospital 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending ☐ Accider ☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MO Lebrum 2012 30. Name and address of person who completed cause of death (Item_23a) (Type, Print) Ulavall CHINTU SHARMA- MO Huspital Center, Westminyla 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

FEB 22

Registrar

Registrar's Signa

| | | for State of Maryla | | | | Mental Hyo | giene 201 | 2 04945 |
|---|------------------|--|---------------------|---|---------------------------|------------------------------------|----------------------------------|---------------------------------|
| | | Registrar 1. Decedent's Name (First, Middle, Last) | Cel | rtificate of D | peatn | 7 | Reg. No. | |
| Physicia | | | D l. | | | 2. Date of Dea Month | Day Yes | 3. Time of Death |
| Medi Examir | | Luevenia Younger 4a. Facility Name (if not institution, give street and number) | Dick | erson | Location of Death | Februar | | |
| d | ici | Larkin Chase | | Bowie | Location of Deati | | 4c. County of D | George's |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. | last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | h 9. | Birthplace (State or Foreign |
| Director | | 578-16-8844 1 □ M 2 X F 97 | Yrs. | Months Days | Hours Min. | Dec. I | 0, 1914 v | Country) irginia |
| d d | ١. | Usual Residence of Decedent 10a. State 10b. County 10c. C | | | | | | |
| ırylan I-f sh ied a | [왕 | 100.0 | City, Town or Lo | | | | | 10d. Inside City Limits |
| r 28g | 洁 | MD Prince George's I | Landove | | | | | 1 ☐ Yes 2X No |
| /ith tr | ā | | | 10f. Zip Code | 0.5 | | 10g. Citizen of What | Country? |
| ems r mu | Funeral Director | 7009 Flagstaff Street 11. Marital Status 12. Was Decedent Ever in U | I.S. 13 V | 207 Was Decedent of His | | ecify Ves or No- | U.S.A. | merican Indian, |
| 6 ter de mine | by | Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No | Ī | f Yes, specify Cubar | n, Mexican, Puerto | Rican, etc.) | Black, W | |
| JO3 | | 3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. | 1 | 1 ☐ Yes 2 🗓 No | Specify: | | Specify: B | lack |
| 2 hot "nat | plei | 15. Decedent's Education (Specify only highest grade completed) | 16a. Deced | dent's Usual Occupa kind of work done d | ation | dina | 16b. Kind of Busine | ss Industry |
| T21 thin 7 than than | Completed | Elementary/Seconday (0-12) College (1-4 or 5+) | life. De | O NOT use retired) | anny most or worr | ung | Own Hom | |
| Ed wi Hygie shr, ti | Be (| 6 17. Father's Name (First, Middle, Last) | п | omemaker | 40.44.0 | | | е |
| Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hyglene. 27 is marked other than "natural", o traumatic event, the Medical Exam | 욘 | Fitzhugh Lee Younger | | | 18. Mother's Nam Oueen | e (First, Middle, 1 Ester Da | | |
| ary and M s mai | | 19a. Informant's Name/Relationship (Type, Print) | 19b Mailin | og Address (Street a | | | City or Town, State, | Zin Cadal |
| d 2 sł d 2 sł altha altha artra | | Douglas Dickerson - Son | | Flagstaf | | | | 0785 |
| of He | | 20a. Method of Disposition 20b. | Place of Dispo | sition (Name of | | Date | 20c. Location - City | or Town, State |
| Page ment ant: I | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ 4 ☐ Conation 5 ☐ Other (Specify) | irview nurch C | natory or other place Baptist emetery | 2-16 | -2012 | Gretna, V | irginia |
| Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Si nature of Funeral Service, icen ee | 22 | . Name and Address | s of Facility Me | tropolit | an Funera | l Service |
| - DD = 80 | | Lemmy fluin | | 5517 Vine | | | | 22310 |
| | | 23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final | | | , such as cardiac | or respiratory arre | est, | Approximate Interval Between |
| Ph. sician/ Medical | | disease or condition resulting in death) a. | | ENTIA | | | | Onset and Death |
| Examiner | | Due to (or as a consec | quence of): | | | | | |
| | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Indictifying. | quence of): | | | | | |
| uted uted ansit | ami | Cause (Disease or iinjury that initiated events c. | | | | | | |
| rate be executed physician and the burial-transit | edical Examin | resulting in death) Last Due to (or as a consec | uence of): | | | | | |
| ate be | gi | d | | | | | | |
| ertifica ding p | | IF FEMALE: | | | | | | |
| death certificate at the attending post for use as | ä | 23b. Was decedent pregnant in the past 12 months? | al death 3 | | , | | 23d. Date of o | , |
| r the sched the | Physician/M | 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of 9 ☐ Unknown | death 5 L | Other (specify) | | | Month | Day Year |
| v requires that the de sbeen signed by the should be detached | by Pr | Part II. Other significant conditions contributing to death but not re | sulting in the ur | nderlying cause give | en in Part I. | 23e. Did tob | pacco use contribute | to the cause of death? |
| uires uires uld be | ed be | | | | | 1 □ Ye | es 2 🗆 No 3 🗆 | Probably 4 K Unknown |
| aw requires as been sig 2 should b | plet | | | | | 24a. Was ar | n 24b. Were a | autopsy findings available |
| Physician: The law this certificate has ral director, page 2 s | Completed | | | | | autops perforr 1 Yes 2 | y prior to | completion of cause of |
| ian: l | | 25. Was case referred to medical examiner? | | 26. Plac | ce of Death (Check | | 2 KNO 1 L Y | es 2 □ No |
| hysic hysic his ce I direc | 은 | 1 ☐ Yes 2 🛣 No Hospital: | ER/Outpatient | t 3 DOA Other | 4 X Nursing Ho | ome 5 Reside | nce 6 Other (Spe | ecify) |
| ding Ph th. After th funeral | ate: | 27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) | 28b. Time of injury | 28c. Injury : work? | at | | w injury occurred | |
| tend death tor; A | iii | 2 Accident Investigation | | M 1 □ Y | ′es 2 □ No | | | |
| or A after Direc | Certificate | 4 Homicide determined 28e. Place of Injury - At homicide determined | ome, farm, stre | et, factory, office | | 28f. Location (Str City or Town | reet and Number or F , State) | Pural Route Number, |
| spital nours neral | edical | 29a. Certifier 1 Certifying Physician: To the best of my know | rledge death or | ccured at the time | date and place, an | d due to the caus | no(a) and manner as a | totad |
| To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as | Med | (Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of m | n and/or investi | gation, in my opinion | death occurred at | the time date and | d place and due to the | causo(s) and mannor stated |
| Vithi Voth | _ | 29b. Signature and title of certifier | | 29c. License r | | | 9d. Date signed (Mor | |
| , | | · agay | | 1)4 | 4521 | 7 F | eb. 10, 2 | 012 |
| A | | 30. Name and address of berson who completed cause of death (Item | | | 1 0 | W10 C | 11 - 7 1 | MD 207/0 |
| -01- | | 04 5 4 5 4 4 4 4 5 4 4 4 | | ide⊥t Koad | a, Suite | MIS, Co | Tiege Parl | k, MD 20740 |
| Stat Registra | - I | 31. Date filed (Month, Day, Year) S2. Registrar's Signa FEB 2 2 2012 | and | | | | | |
| | | - 10 Marie 1 / // | | | | | | |

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND ITEM#12perFH,G924,2/2872012,WS State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John Langston Dennis 2012 Feb 4:45 Medical 6 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3315 Glenmoor Drive Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months **Director** 578-18-5473 1 X M 2 □ F 91 1920 April 8, Virginia 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Chevy Chase 1 Yes 2 X No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a3315 Glenmoor Drive 20815 USA Page 1 and 2 should be filed within 72 hours after death vnent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. 0 Completed by Black, White, etc. 1 Never Married 2 K Married 2 Na1944-1956 X Yes Maryland 21215-0036 Specify African 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Yes, Give 1942 Year or Dates. American event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ US Government Budget Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Langston Dennis Marie Turnbull other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3315 Glenmoor Dr. Chevy Chase, MD 20815 Elizabeth A. Dennis / wife Baltimore, Important: If iten 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗀 Burial 2 🔀 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final JOurney Crematory 2/18/12 Woodbine, MD of Funeral Service Li Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M 101 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Sub-dural Hematoma days Medical resulting in death) Examiner 3 days Fall - closed head injury if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Exami and burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical requires that the death certificate be Box 68760 the as attending p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnal
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 1 ☐ Yes 2 ☐ Unknown the 9 | Unknown Records, P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by multiple myeloma, chronic renal insufficiency 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has page 2 perform Physician: The 1 Yes 2 No Yes 2 No certific Division of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospita Other: 1 Yes 2 🗌 No 욘 safter dea.. ها Director After ... ۲۷ the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA this (4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending bay Accident 1 Yes 5100m Investigation Unts Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Location (Street and Numb Gity or Town, State) 28e. Place of Injury - At home, farm, street, factory, office Bural Route Number, 4 Homicide determined building, etc. (Specify) Home 20815 Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0051113 2/17/12 30x, 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) MD 10400 Connecticut Ave Suite 606 Kensington, MD 20895 Steven Schwartz, filed 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 19, Carol 2012 Jean Davage 3:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 212-74-7633 **Director** 1 🗆 M 2 🔀 F 5, 71 1940 April Maryland show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f MD N/A1 X Yes 2 No Baltimore ms 23a or must be r 10e. Street and Number 10g. Citizen of What Country? Funeral 1313 Kenhill Avenue 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Black, White, etc. ō þ 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 0 Disabled Never Worked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unk. Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) epartment of Health a mportant: If item 27 is only injury or other trains Jeanne Manning, caregiver 1313 Kenhill Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 \square Burial 2 $\overset{f X}{f X}$ Cremation 3 \square Removal from State metro Crematory, Inc. 02/20/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. Sec 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) consequence of) Examiner Sequentially list conditions, if any hading to in mediate cause. Enter Underlying Due to (or as a nonsequence of): Exami Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending I for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available 24a. Was an page 2 s Jas autopsy prior to completion of cause of death? certificate 2 No 1 Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 \square Pending Natural injury within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signatur and title of certifier 32850

State Registrar

3:05am

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MO

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 22 per fh 9924 2-22-12 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Dav Month Year **Physician** PM Margaret 18:40 Fit zacrald Febravary 20 2012 /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔽 F 54 Yrs Director 577-80-5972 1-3-58 Wash DC Usual Residence of Decedent the Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD. P.G. Cheverly 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other there was any highly or other traumaster. vith ò Items 23a or ner must be n 2910 Cheverly Oaks Court 20785 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ģ Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lenora Colwell William Wiggins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 19a. Informant's Name/Relationship (Type. Print) Reginald Fitzgerald/Husband 2910 Cheverly Oaks Ct. Cheverly, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Riverdale Park 2/23/12 Riverdale, Md. 4 ☐ Donation 5 ☐ Other (Specify) f uneral Service Licensee 22. Name and Address of Facility Latimore, Funeral Services PA

11. The Property of the Part of the Pa 21. Signatury Hac Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between mediate Cause (Final Onset and Death **Physician** Pseudomona disease or condition resulting in death) week /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2**▼** No Yes P.O. Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Tes 2 No 3 Probably 4 Donknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has 1 Yes 2 No 2 **X**No 1 Tyes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) No No 2 ER/Outpatient 3 DOA မ 24 hours after death.

Funeral Director: After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1X Natural 2 Accident 1 Tes 2 🗌 No filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) completely 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year, KES-000 rebruary 20,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001
11595

State

ARVINO

31. Date filed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Feb 5. 2012 6:40a M Inez L. Fallin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore Baltimore** Frederick Villa Nursing Center Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last hirthday) 8. Date of Birth 1 🗆 M 2 屎 F Days Min (Month, Day, Year) Mar 12, 1922 **Director** 89 223-26-9427 Usual Residence of Decedent 28a-f shov 10a, State 10b County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No **Baltimore Baltimore City** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21223 4 North Carey Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: **Black** 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **Baltimore City School** Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lessie Dobyns Andrew Dobyns oermit. Page 1 and 2 should Department of Health and Ме Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 North Carey Street Baltimore, MD 21223 Robert Fallin 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Lansdowne, Maryland Feb 13, 2012 4 Donation 5 Other (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 art 1. En er the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on y ch line. Approximate Interval Between Onset and Death Physician/ vanced disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Dav 2 No ed by the a detached f 9 Unknown a | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page perform 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work To the Hospital or Attendir within 24 hours after death. To the Funeral Director, Af 1 Yes 2 No Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)20303 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address SIGN Poll

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012

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| | | | 1 - State Registrar | Certificate of Death | | eg. No. | |
|-------------|--|------------------|--|--|---|--|--|
| | Physicia | ın/ | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Deat Month | Day Year | 3. Time of Death |
| Sec. | Medic | al | HARRY GORDON GRUNDY 4a. Facility Name (if not institution, give street and number) | 4. 0% T | Februar | | |
| and. | Examin | ier | GILCHRIST HOSPICE CENTER | 4b. City, Town, or Location of Death Towson | | 4c. County of Dea | e County |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd | | 8. Date of Birth (Month, Day, | 9. Bi | rthplace (State or Foreign |
| | Director | | 023-12-5093 | , | Dec 18, | | ssachussetts |
| | and show dat | Po | 10a. State 10b. County 10c. City, Town of | r Location | | | 10d. Inside City Limits |
| | Maryl 28a-f otified | irect | Maryland Baltimore County | Towson | | | 1 ☐ Yes 2 🌠 No |
| | h with the ns 23a or nust be n | Funeral Director | 212 Aigburth Avenue, Apt 306 | 10f. Zip Code 21286 | | 10g. Citizen of What C | ountry? |
| 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. | by | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No WWIII If Yes, Give Year or Dates. | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto Yes 2 M No Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Am Black, Whi Specify: Wh | |
| 15-0 | 72 hou "natu ledica | Completed | (Specify only highest grade completed) (G | ecedent's Usual Occupation live kind of work done during most of work | king | 16b. Kind of Business | s/Industry |
| 212 | vithin liene. | | Elementary/Secondary (0-12) College (1-4 or 5+) | e. DO NOT use retired) Chemist | | Rubber C | Company |
| | filed val Hyg | Be c | 17. Father's Name (First, Middle, Last) | | ne (First, Middle, N | | |
| yla | uld be Ment narker natic e | မ | Harold Gordon Grundy | Mario | | Gay | |
| Maryland | 2 shorth and the and the strain traum | 3 | | Mailing Address (Street and Number or Rur 19 Holden Road, Tow | | | |
| | 1 and of Heal item 2 | | 20a. Method of Disposition 20b. Place of D | isposition (Name of | 1 | 20c. Location - City o | |
| Baltimore, | Page ment c tant: If | | 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State demetery, 4 ☐ Donation 5 ☐ Other (Specify) | crematory or other place) Count Crematory 2/22 | 2/2012 | Baltimore | , Maryland |
| Balt | permit. Depart Import any inj | j | 21. Signatur Furral ever consumments D. Lawson | MTCHELL WIEDEFELD 6500 York Road, Ba | FUNERAL 1timore, | HOME, INC Maryland | 21212 |
| إحسا | Ph _y si i n ∤ Medical | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) | enter the mode of dying, such as cardiac | or respiratory arre | st, | Approximate Interval Between Onset and Death |
| - | Examiner | | Tue to (or as a consequence of): | | | | ' |
| | — | iner | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying | | | | |
| Pelin | cate be executed physician and the burial-transit | Examiner | Cause (Disease or injury that initiated events c. | | | | |
| 6 | be exe sician burial | | resulting in death) Last Due to (or as a consequence of): | | | | |
| 8760 | i o o o o | Medical | d | | | | |
| Box 6 | The law requires that the death certi ate has been signed by the attendin page 2 should be detached for use | Physician/N | FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | 23d. Date of do Month | elivery Day Year |
| ds, P.O. | requires that the been signed by should be deta | by | Part II. Other significant conditions contributing to death but not resulting in t | he underlying cause given in Part I. | 23e. Did tob | pacco use contribute t | o the cause of death? |
| Records, | The law recate has be page 2 sh | Completed | | | 24a. Was ar autops perforr 1 🗆 Yes 2 | y prior to ned2 death? | utopsy findings available completion of cause of |
| ital | ysician: The s certificate director, pag | Be C | 25. Was case referred to medical examiner? 1 Yes 2 Hospital: I Inputient 2 EP/Output | 26. Place of Death (Chec | | <u></u> | [dere' |
| on of Vital | nding Physith. th. the After this e funeral d | cate: To | 27. Manner of Death 1 Inpatient 2 I ER/Outp 28a. Date of injury (Month, Day, Year) 28b. Tirr inju 2 Accident Investigation | e of 28c, Injury at | ome 5 ☐ Reside 28d. Describe ho | ence 6 N Other (Spe w injury occurred | cify) VW>Y)[C |
| Division | Hospital or Attending Physician: 24 hours after death. Funeral Director After this certific tely filled in by the funeral director, | Certificate: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify) | , street, factory, office | 28f. Location (Str City or Town | reet and Number or Ru , State) | ural Route Number, |
| _ | To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b | Medical | 29a. Certifier (Check (Check only one) Certifying Physician: To the best of my knowledge, de 2 ☐ Medical Examiner: On the basis of examination and/or in 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, de | vestigation, in my opinion, death occurred a | t the time, date and | d place, and due to the | cause(s) and manner stated. |
| | Noth | | 29b. Signature and title of certifier | 29c. License number 583 C | 3 F | 9d. Date signed (Moni | th, Day, Year) 20 202 |
| | D | | 30. Name and address of person who completed cause of death (Item 23a) (Type AMW) A CHANGES (WO | 6701 N. Cha | nces s | - Tawso | N MO |
| | Stat Registra | | 31. PEBd (107h) (17h) 32. Regular's Shares | • | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9513 pm Elizabeth Green Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) 212-42-5813 Director 1 🗆 M 2 🗓 F 89 Yrs. 2-7-1923 SC Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at Director 1 Yes 2 No 28a-f MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21229 USA 105 S. Kossuth Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Black, White, etc. ō þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: African-American If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3√2 Widowed 4 □ Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6th Honemaker Damestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lizzie Davis Jimmie Peterkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Major/Daughter 1345 Sherwood Avenue, Balto, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-21-2012 Finksburg, MD Gardens Of Etecnal Hope 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service License 7 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final 9 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) been signed by the atter should be detached for in the past 12 months?

1 Yes 2 No Day Year Month 9 Unknowk Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Aduancea Demonta 1 🗌 Yes EL12abet# 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation
6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month

2120

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 19 2012 11:55P M SHIRLEY GOLDBERG Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON Birthplace (State or Foreign Country) If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8 Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 109-14-1604 1 🗆 M 2 🗶 F 88 02/27/1923 PA Usual Residence of Decedent shov 10a. State 10h County 10c. City, Town or Location 10d Inside City Limits the Maryland Director notified 28a-f 1 Yes 2 X No MD BALTIMORE REISTERSTOWN 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 2307 RIDGE ROAD death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten I Examiner n 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced "natural" WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) OWNER CHILDRENS CLOTHING Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည RICHARD GINSBERG BETTY GOLDSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a GARY MELNICK / SON 2307 RIDGE ROAD, REISTERSTOWN, MD 21136 other 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State constery, crematory or cther place)
MIKRO KODESH
BETH ISRAEL CONG. Page 1 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State ö Department of Important; If any injury or once, 02/21/2012 4 Donation 5 Other (Specify) BALTIMORE, MD Signature unal Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Fan 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Desili Physician/ disease or condition resulting in death) KNS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijury that initiated events Due to (or as a consequence of): Exami burial-transit death certificate be executed and Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year the detached a Unknown 9 Unknow signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform performed? 1 ☐ Yes 2 Ø No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify WSOLU) within 24 hours after death.

To the Funeral Director: After this funeral (27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending Natural 5 Pending injury 1 ☐ Yes 2 ☐ No filled in by the Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific ebnary 20 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST TOWSON S 6701 2 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

| 12-01432 | _ | | | pe or Print | | | | | | | | gible. | | | | |
|---|---------------------------------|--|---------------------------|---|-------------------------------|---------------------------------|---------------------------|------------------------|--------------------|--------------|-----------------------|----------------------|------------------------------------|--------------------------|-----------------------------------|---------------|
| Lazaro Cardenas | 1 F | nzales I- For State Registrar 1. Decedent's Nam | | tate of Mary | | epartment Certificate | | | Menta | | | Reg. No. | 201 | 2 | <u> </u> |) |
| Physiciar Medical Examin | 1/ | | , | nas Gonza | les | | | | | | Month ebruary | | Year | 3. | Time of Death 0453 hrs | |
| | | | if not institution | on, give street and i | | | | Town, or Ler Spring | Location of I | | <u>_</u> | 4c. (| County of Dontgomer | | | _ |
| Funeral Director | | 5. Social Security N | | 6. Sex | | vrs. last birthday) | If Un Mont | der 1 Year ths Days | | Min. | Date of Bi | , | Fo | Birthp reign Count | ace (State or Guatemala ry) | – а |
| any | | Usual Residence o 10a. State | f Decedent 10b. County | | 10c. | City, Town or Loc | cation | | | | | | | 10 | d. Inside City Limit | ts |
| ath with the Maryland items 23a or 28a-f show any set be notified at once. | اة | Maryland | Montg | gomery | | Si1 | ver S | Spring | g | | | | | 1 | Yes 2 X N | ю |
| Maryl r 28a-1 | Director | 10e. Street and Nu | | | | | | ip Code | | | 1 | 10g. Citize | en of What (| Country | ? | |
| with the | <u>e</u> | 11510 II | ngelwo | | ecedent Ever i | in U.S. 13. V | Vas Deced | 2090 dent of Histo | 06 panic Origin | ? (Specify | Yes or No | Gu | atema | | Indian, Black, | |
| death with the Maryland or items 23a or 28a-f sho must be notified at once | runeral | 1 X Never Marri | | larried Armed | Forces? | lo l | f Yes, spec | cify Cuban, | Mexican, P | Puerto Rica | n, etc.) | ĺ | White, et | | , maran, basis, | |
| rs after ural", miner | ᇍ | 3 Widowed | | vorced If Yes, Give Y or Dates: ecify only highest gr | ear | 1X | | | specify: (| | | | pecify: H | | | |
| Baltimore, MD 21215-0036 Permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Ex miner must be notified at once | Completed | Elementary/Seco | | | (1-4 or 5+) | during | most of we | orking life. | DO NOT us | | done | 100. NI | id of Busine | iss/indi | istry | |
| 5-0036 lled within 7: Hygiene. t other than the Medical | E - | 12 17. Father's Name | (First Middle | Last) | | Br | ickla | | 8.Mother's | Name /Fin | et Middle | | nstru | cti | on | |
| 215 be filed intal Hy rked of | 8 | Lazaro C | ardena | s Martin | ez | | | Ι. | | , | E. (| _ | , | | | |
| MD 2121 (d 2 should be fill lith and Mental Fill no 27 is marked numatic event, in T. D. | 2 | 19a. Informant's Na | | | | | | | | | | | or Town, S | | | |
| ore, ME s 1 and 2 s of Health au If item 27 ner traums | - | 20a. Method of Dis | position | Brother | | 0b. Place of Disp | osition (Na | ant Av | venue netery, | Si Ly Da | <u>er S</u> t | pring 20c. Lo | Mar ecation - City | vla or To | nd 20910 wn, State | _ |
| imor Pages ment of tant: If or other | | | Cremation Other S | | from State | crematory or Metro Cr | | | nc. (| 02/21 | /12 | Ba | ltimo: | re. | Maryland | 1 |
| Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other tr | | 21. Signature of Fu | | W. L. | nas Gre | egor C | . Name an | d Address | of Facility | tv Of | Marv | land | . Inc | | 1 21228 | - |
| Physician | + | 23a. Part I. Enter th | ne disease, or | complications that | - | 2 ath. Do not ente | 99 Fr | ederi | ick Ro | pád B | altin piratory arr | est, shock | Mary c, or heart | lap | 1 21228 Approximate Interva | al |
| /Medical Examiner | | failure. List on Immediate Cause (| Final disease | | pine a | nd Alcol | no1 I | ntoxi | catio | n | | | | | Between Onset and Death | d |
| | 1 | or condition resulti | | Due to (or as b. | a consequent | ce of): | | | | | | | | | | |
| | | Sequentially list co if any, leading to in cause. Enter Unde | nmediate | | a consequen | ce of): | | | | | | | | _ | | _ |
| ed nsit | Xall | (Disease or injury t events resulting in | hat initiated | Due to (or as | a consequent | ce of): | | | | | | | | + | | _ |
| ecut and | <u> </u> | X UNPENDED | | d | 23a . 27 | ,28a-f, _j | oer m | e - e92 | 5 3-1 | -12 9 | em | - | - | + | | _ |
| 760, ficate be ex g physician the burial | 5 | F FEMALE: | | 23c. If yes | , outcome of p | | | -,6,2 | | | | 23d. | Date of deli | very | | _ |
| Division of Vital Records, P.O. Box 68760, Hospital or attending Physician: The law requires that the death certificate be explanated after death. Funeral Director: After this certificate has been signed by the attending physician rely filled in by the funeral director, page 2 should be detached for use as the burial of Certification: To Be Completed by Diversion Medicial | | 3b. Was decedent past 12 months | ? | 4 Preg | birth gnant at time o | , | Fetal death Other (Spe | | Ectopic pi | regnancy | | М | lonth | Day | Year | |
| the dea by the a | r E i | 1 Yes 2 N | | g Unki | nown | not resulting in the | underlyin | n cause niv | ven in Part I | | 23e Did to | obacco us | e contribute | to the | cause of death? | _ |
| Division of Vital Records, P.O. tal or attending Physician: The law requires that the ris after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached by the partification. To Be Commissed by the partification. | n nò | | | _ | | | | .g 04400 g.v | | | | | | | y 4 🗸 Unknown | |
| Records, P.C. The law requires that ficate has been signed t, page 2 should be deter | | | | | | | | | | | 24a. Was | | | | sy findings availabl | |
| Reck The lar | 5 | ¥ | | _ | | | | - | | _ | perfo 1 🗸 Yes | rmed? 2 No | death 1 | | 2 No | |
| Vital Rec ysician: The l this certificate l director, page | מ בי מ | 25. Was case reference examiner? | | Hospital: | Innationt 2 | ✓ ER/Outpatie | nt 3 | | of Death (Ch | heck only of | | Residenc | 20 6 0 | her: | | _ |
| of V ing Phy After th | <u>.</u> 2 | 27, Manner of Deat | 2 No | 28a. Date | e of Injury th, Day, Year) | 28b. Time o | | 28c. Injury | , | | Describe | | | iller. | | _ |
| Sion Mitendi death. ctor: / | , allo | 1 Natural 2 Accident | 5 Pend Inve | ding fd 2 | -18-12 | | | | es 2 🗶 No | | nknow | | | | | |
| Division of Vi To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di | | 3 Suicide 4 Homicide | 6 X Coul | d not be 28e. Pla (Specify | | At home, farm, str and at ho | | y, office bu | illding, etc. | 28f. | or Town, S | Street and State) 11 | Number or 510 I on MD | Rural d 1e v | Route Number, City | y |
| e Hospi 124 hou e Funer etely fil | <u> </u> | 29a. Certifier 1 | | hysician: To the be | est of my know | vledge, death occ | urred at th | | | , and due | to the caus | se(s) and | manner as s | tated. | | |
| To the Ho within 24 To the Fu completely | ָבְּבְּרָהְיִי בַּבְּרָהְיִי | 29b. Signature and | | miner: On the basis and manner | of examination stated. | on and/or investig | | | | rred at the | time, date | | | | | |
| | | .so. oighature and | aue or cerune | 7 201 | 16 | , | 29 | o.C.M | | | | | ite signed <i>(i</i> Jary 18, 2 | | ש, rear) | |
| Okand | 3 | | . / | who completed car | , | , | | | | | | | | | | _ |
| F √ | | Jack Titus N | · | outy Chief Med | | | Baltimo | ore Stree | et, Baltim | ore, ME | 21223 | | | | | _ |
| Stat Registra | | FEB 22 | 72(119ear) | 32. F | Regis ar's Sig | reture | | | | | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

| | | | For State (| of Marylan | | irtment of L tificate of D | | | | 0 01051 |
|---------------------------------|---|--------------|--|--|---------------------------------------|---|---|--------------------------|-------------------------|---------------------------------|
| | Dharini | / | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Dea | | 3. Time of Death |
| 25 | Physicia Medio | | | MBRIGH | 17 | | | Month FEB | 17 201 | 2 2:51 AM |
| | Examir | er | 4a. Facility Name (if not institution, give street and num HEARTLAND HOUSE | ŕ | | 4b. City, Town, or Grason | Location of Death | 1 | 4c. County of D | ANNES |
| Ī | Funeral | 1 | 5. Social Security Number 6. Sex | 7. Age (In yrs. la | st birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birt | h g. | Birthplace (State or Foreign |
| | Director | | Usual Residence of Decedent | 90 | Yrs. | Months Days | Hours Min. | (Month, Day 64 - 28 | Year) MA | RYLAND |
| | and show dat | ē | 10a. State 10b. County | 10c. City | , Town or Loc | ation | | | | 10d. Inside City Limits |
| | Mary 28a-f otifie | Director | Maryland Queen Anne's | Stev | vensvil | L1e | | | | 1 ☐ Yes 2 🔀 No |
| | ith the 3a or t be n | ra D | 10e. Street and Number 6310 Kent Point Road | | | 10f. Zip Code 21666 | | | 10g. Citizen of What | Country? |
| | ems ? | Funeral | 11. Marital Status 12. Was Dece | edent Ever in U.S | . 13. W | as Decedent of Hi | spanic Origin? (Sr | ecify Yes or No- | U.S.A. | merican Indian, |
| 36 | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | ξ | 1 Never Married 2 Married Armed Fo | rceş? 2 🔯 No | lf lf | Yes, specify Cuba | n, Mexican, Puerto | Rican, etc.) | Black, W | hite, etc. |
| 9 | atural | eted | 3 Widowed 4 Divorced Year or Di | | | ent's Usual Occupa | | | Specify: Wh | |
| 215 | in 72 h e. nan "n Medi | Completed | (Specify only highest grade completed, Elementary/Seconday (0-12) College (1 | | (Give ki | ind of work done d NOT use retired) | | king | 16b. Kind of Busine | ss Industry |
| 121 | led within Hygiene. other tha ent, the N | Be Co | 6 | | Но | omemaker | | | Own Hon | ie |
| Maryland 21215-0036 | should be filed vand Mental Hyg 7 is marked othe raumatic event, | 70 E | 17. Father's Name (First, Middle, Last) Clifford Davis | | | | 18. Mother's Nar Naome I | | Maiden Surname) | |
| ary | should be file and Mental is marked o | | 19a. Informant's Name/Relationship (Type, Print) | <u> </u> | 19b. Mailing | Address (Street a | | | City or Town, State, | Zip Code) |
| | and 2 s Health s em 27 i | | Andrew R. Hambright (Son |) | | | | | ille, MD 2 | ' ' |
| nore | age 1 and of H | | 20a. Method of Disposition 1 Burial 2 La Cremation 3 Removal from | State ce | metery, cremi | ition (Name of atory or other place | | Date | 20c. Location - City | |
| Baltimore, | permit. Page 1 Department of Important: If it any injury or o | | 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lights 4 | Lai | | Cremator | | 5-12 | Lansdale | |
| m | any Der | | X Jenny tellum | _ | Me 55 | tropolit 17 Vine | an Fúner St., Ale | al Servi xandria | ice VA 22310 | |
| | | | 23a. Part 1. Enter the disease, or complications that constant, or heart failure. List only one cause on ear | caused the death ch line. | . Do not enter | the mode of dying | , such as cardiac | or respiratory arre | est, | Approximate Interval Between |
| | Pnysician/ Medical | | reculting in death) | ure to ! | | | | | | Onset and Death |
| | Examiner | | Adva | | | with Deb | oility | | | |
| , | p # | Examiner | cause. Enter Underlying | or as a conseque | nite off | | | | | |
| 10 | ecute and II-trans | Exan | Cause (Disease or iinjury that initiated events c | or as a conseque | ence of): | | | | | |
| 2092 | icate be executed physician and s the burial-transit | edical | d | | · | | | | | |
| 928 | tificate ng phy as th | Med | IF FEMALE: | | | | | | | |
| Box 68 | ath cei attendi for use | cian/ | in the past 12 months? | come of pregnan Birth 2 ☐ Fetal nant at time of de | death 3 | Ectopic pregnancy Other (specify) | / | | 23d. Date of Month | delivery Day Year |
| Ö. | the de | Physician/M | 1 Yes 2 X No 4 Pregi 9 Unknown 9 Unkn | | | Other (specify) | | | | |
| Division of Vital Records, P.O. | s that gned b | þ | Part II. Other significant conditions contributing to de Hypertension | eath but not resu | Iting in the un | derlying cause give | en in Part I. | | | to the cause of death? |
| rds | require been si | eted | Anxiety Syndrome | | | | | | | Probably 4 Unknown |
| ecc | he law e has l | Completed | Depression | | | | | 24a. Was a autop: perfor | sv prior t | |
| a F | ian: Ti artificat ctor, pa | Be C | 25. Was case referred to medical examiner? | | | 26. Pla | ce of Death (Chec | | 2 № No 1 🗆 ` | ∕es 2 □ No |
| Ę. | Physic this ce al dire | 유 | 1 Yes 2 No Hospital: | Inpatient 2 🗆 E | · · · · · · · · · · · · · · · · · · · | | 4 L Nursing H | ome 5 Reside | As ence 6X Other (Si | sisted wakng |
| 0 0 | rding l | Certificate: | 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation 28a. Date of (Month) | of injury 2 h, Day, Year) | 28b. Time of injury | 28c. Injury work? M 1 \(\sigma\) | | 28d. Describe ho | w injury occurred | |
| visio | r Attel ter des rector | ertifi | 3 Suicide 6 Could not be 28e. Place | of Injury - At hom | ne, farm, stree | | | | reet and Number or I | Rural Route Number, |
| ٥ | pital o | | | | | | | City or Towr | , | |
| | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after decath. Within 24 hours after decath. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as | Medical | 29a. Certifier (Check conly one) 1 Certifying Physician: To the best only one) 3 Certifying Nurse Practioner: 1 | is of examination a To the best of mv I | and/or investig knowledge, de | ation, in my opinior ath occurred at the | i, death occurred a time, date and pla | t the time, date an | d place, and due to the | e cause(s) and manner stated. |
| / | Vithi Vithi Con | | 29b. Signature and title of certifier | | . 3-, 40 | 29c. License | number | 2 | 9d. Date signed (Mo | nth, Day, Year) |
| • | | | 1 Cluckon | my MA | 1 | 1)23 | 389 | | 2/17/ | 12 |
| | 4 | | 29b. Signature and title of certifier Clucker 30. Name and address of person who completed cause The Amagenta of the State of the St | of death (Item 2 | 23a) (Type, Pri | nt) | A Chilos | Tra F | Medzi | (120 |
| | State | | 31. Date filed (Month, Day Year) FEB 2 2 2012 June 1 | egisty r's Signatu | alas . | 1 ms / me | 1, CIXER | per / Desc | y overy cy | C 50 |
| | Registra | r | LED 2 & COIC Kenery | 10. 14 m | | | | | | |

| | | | 1 - For State Amend Item | State on 25 per m | of Marylar e,g924, | nd / Dep 02/15/ | artment of h 2012dhb rtificate of L | Health a Death | and M | ental Hyو ا | giene Reg. No. 🤈 (| 112 | 01.055 |
|--------------------------------|--|--------------------------|--|---|---------------------------------|----------------------------------|--|----------------------------------|---------------|--------------------------------|-----------------------|--------------------------------------|---|
| | Physicia | · / | Decedent's Name (First, Midd | | | | | | | 2. Date of Dea | ath | J L | 3. Time of Death |
| ,400 mg | Medic | cal | 4 5 33 44 66 11 11 11 | | Robert Ho | gg Jr. | | | | January | IO Day | 2012 | 12:10 P M |
| - | Examir | er | 4a. Facility Name (if not institution St. Thomas More Nu | | | Center | 4b. City, Town, or | r Location c 'Hyatts | | | | y of Death Price Ge | eorge's |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. i | | If Under 1 Year Months Days | | | 8. Date of Birt | h | 9. Birthr | place (State or Foreign |
| | Director | | 206-34-3603 Usual Residence of Decedent | 1 X M 2 □ F | 67 | Yrs. | Months Days | Hours | IVIII I. | 10/31 | 1944 | Per | insylvania |
| | and show dat | ō | 10a. State 10b. Count | у | 10c. Cit | ty, Town or Lo | cation | | ······ | | | 1 | 0d. Inside City Limits |
| | Maryl 28a-f otifie | Director | VA | Warren | | | | Front R | oyal | | | | 1X Yes 2 No |
| | ith the 3a or t be n | a D | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citizen of | | • |
| | ems 2 | Funeral | 608 W. Strasburg | | edent Ever in U. | S. 13.1 | Was Decedent of H | 22630 ispanic Orio | | ifv Yes or No- | 14 Ba | USA ce - Americ | |
| စ္တ | fter de , or it amine | þ | 1 Never Married 2 Ma | Armed Fo | orces? | | f Yes, specify Cuba 1 ☐ Yes 2 X ☐ No | ın, Mexican | , Puerto Ri | ican, etc.) | Bla | ck, White, | |
| Ö | 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at | 3 √ Widowed 4 □ Divorced | | | | | | | | | Specify | W | hite |
| 215 | n 72 h t. an "na Medic | mpl | | nest grade completed, College (1 | | (Give | dent's Usual Occup. kind of work done o O NOT use retired) | | of working | 9 | 16b. Kind of E | Business Ind | dustry |
| 21 | ygiene. her thar t, the N | | 12 | 1 | -4 Or 5+) | | Drywall | Installe | er | | C | Construc | tion |
| and | be filed ental Hy ked oth ic event | To Be | 17. Father's Name (First, Middle, | • | | | | 18. Mothe | er's Name (| | Maiden Surnam | , | |
| aryl | should I and Me s marl raumati | | 19a. Informant's Name/Relations | Charles Robert ship (Type, Print) | Hogg Jr. | 19b. Mailir | ng Address (Street a | and Numbe | er or Rural I | | Teresa Sn | | Code) |
| Σ | and 2 sl Health a tem 27 l | | Meghan Erin Gurley | / Daughter | | 1 | . Strasburg R | | | | | | |
| Baltimore, Maryland 21215-0036 | - 7 E C | | 20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation | 3 Removal from | | Place of Dispo cemetery, cren | sition (Name of natory or other plac | re) | Da | ate | 20c. Location | - City or To | wn, State |
| Ħ | permit. Page Department o Important: If any injury or once. | | 4 Donation 5 Other 21. Signature of Funeral Service | , | | | ke Crematory | | 1/11/2 | 2012 | Ве | eltsville. | , MD |
| Ba | 21. Signature of Funeral Services censee 22. Name and Address of Facility Maryland Cremation Services, PO BOX 14 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | | | X 1413,Ba | altimore | , MD 21203 |
| П | | | 23a. Part 1. Enter the disease, of shock, or heart failure. List | r complications that o | caused the deat ich line. | h. Do not ente | er the mode of dying | g, such as o | cardiac or I | respiratory arre | est, | | Approximate Interval Between |
| | Physician/ Medical | 8 | Immediate Cause (Final disease or condition resulting in death) | a. Pa | USTEN | | encen | WITH | Me | itas T | uses | 1 | Onset and Death 1 CURS |
| | Examiner | | , and a second | Due to | (or as a consequ | uence of): | | | | | | | |
| | _ + | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Lua to | or as a consequ | sénce orj: | | | | | 11 | | |
| | ecutec and -transi | Examiner | Cause (Disease or iinjury that initiated events resulting in death) Last | c. Due to i | or as a consequ | ience off: | | |) v | A | AL EXAMINER | | |
| 0 | icate be executed physician and s the burial-transit | edical | rooding in dodn'y East | L _d | ,0. 40 4 00004 | 301100 0171 | | CERTIFICAT | TIONAPPRO | OVED BY MEDIC | | | |
| 876 | tificate ng phy as the | Med | IF FEMALE: | | | | | | , | | | | |
| 9 X | ith cert | ian/ | 23b. Was decedent pregnant in the past 12 months? | 1 Live | come of pregna Birth 2 Feta | al death 3 | Ectopic pregnanc | у | | | 1 | ate of delive | |
| P.O. Box 68760 | he des y the a iched f | by Physician/M | 1 Yes 2 No 9 Unknown | 9 Unkr | nant at time of c nown | death 5 L | Other (specify) | | | | 1010 | Shui | Day Year |
| P.0 | s that t gned b | by P | Part II. Other significant conditi | | | | | | | 23e. Did to | bacco use cont | tribute to th | e cause of death? |
| rds, | equire een sig | eted | Respirato | ny +3,11 | upe / | vent | later o | CALM | deni | 1 🗆 Y | es 2 🖾 No | 3 Prob | oably 4 🗌 Unknown |
| eco | e law n has b ge 2 sk | Completed | Quadrag | epia /1- | araw | eopla | oit Syn | clac | me | 24a. Was a autops perfor | sy | Were autop prior to cor death? | osy findings available appletion of cause of |
| œ e | an: The tificate or, pag | Be Co | 25. Was case referred to medical | 1 | | _ | 26 Pla | ace of Death | h (Check o | 1 Tes | | 1 Yes | 2 🗆 No |
| ξ | hysicia nis cer I direct | To B | examiner? 1X Yes 2 X No | Hospital: | Inpatient 2 🗆 | ER/Outpatien | Othe | | | | ence 6 🗆 Oth | er (Specify) | |
| Division of Vital Records, | ding P | | 27. Manner of Death 1 ↑ Natural 5 □ Pendi | 19 | of injury th, Day, Year) | 28b. Time of injury | 28c. Injury work | at | 28 | | w injury occurr | | |
| Sio | Attender deatl | Certificate: | 2 Accident Invest 3 Suicide 6 Could 4 Homicide detern | | of Injury - At ho | me, farm, stre | M 1 📙 | Yes 2 □ I | - | Bf. Location (St | reet and Numb | er or Rural | Route Number. |
| <u>S</u> | ital or irs afte al Dire | | 4 - Homicide determ | buildir | ng, etc. (Specify |) | | | | City or Towr | | | |
| | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical | (Check 2 Medical | g Physician: To the be Examiner: On the bas Nurse Fractioner: | is of examination | and/or invest | igation, in my opinio | n. death occ | curred at th | e time, date an | d place, and du | e to the cau | ise(s) and manner stated. |
| | Verithin Control | | 29b. Signature and title of certifie | r 0 | |) | 29c. License | number | | 2 | 9d. Date signe | d (Month, E | Day, Year) |
| | (2) | | Hunch | | g hm | 20) / = = | 1001 | 42 | cy_ | | Bouge | 24 10 | 2,2012 |
| | 0 | | Paul A. Do | VORE ML | 4203 | Due | ensburg | Rel | Haya | Hsu | ile Mu | 0 2 | 3781 |
| I | Stat Registra | · | 31. Date filed (Month, Day, Year) FEB 1 6 20 | 32. HE | egistrar's Signat | bark | | | | | | | |
| | riegistic | | FED I U AU | ic Buch | V 10. | THE CALL | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** ATRICIA 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CEN 112 BALTIMON ONG If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 🗓 F 86 Dec 5. Illinois 1925 Director 217-24-1434 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Exemitment to an event, 1 Yes 2 □ No Funeral Director N/ABaltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 401 Notre Dame Lane 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐Yes 2X No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Business Office Secretary 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Edgar George Horn Mae Kelley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Niece + P.R.) 45 Judges Lane, Towson, Maryland Sharon T. Derr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Green Mount Crematory 2/21/2012 21. Signatur of Funtral Service Leaves Martin D. Lawson Name and Address of Facility ICHELL-WIEDEFELD FUNERAL HOME, INC. 21212 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KUPTUVED **Physician** /Medical Examiner TOVOSC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician and for use as the burlal-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ج</u> 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: , 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 2,20,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PULLIMOVE, MD 2/2/2 115 EAST MIZITOSE AUG

Registrar

DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Eddie Myers Harri | | S - For State | ate of Mar | yland / | | | | | and | Menta | l Hy | giene | 9 | 2.0 | 1 / | 2 010 | - |
|--|---------------|--|--|--------------------------|--------------------------|-------------------|------------|----------------------|----------|-------------|---------------------|--------------------------|---------------------|--------------------------|--------------|---|-----------|
| | | Registrar 1. Decedent's Name (First, Midd | llo Loot\ | | Cer | rtificate | of D | eath | | | 13 | 2. Date of De | Reg. No | . <u> </u> | | 3. Time of Death | Ö |
| Physician Medical Examination | - | Month Day Year | | | | | | 1117 hrs | | | | | | | | | |
| | | 4a. Facility Name (if not instituti | | d number) | | | | | | Death | 4c. County of Death | | | | | | |
| | 4 | 421 W. Pulaski High | 6. Sex | 7 Age | (In ure Is | ast birthda | | Elkton If Under 1 | Vaar I | If Under 2 | 2/IHre | 8 Date of F | | Cecil | Q Rieth | place (State or | |
| Funeral Director | | 218–90–4818 | 1 M 2 | _ | 47 | | | | Days | Hours | Min. | Jun 4 | • | 1 | Foreign | | bi |
| | Ŀ | Usual Residence of Decedent | 'LA'' | | | | | | | | | Jour . | | J 1 | | *************************************** | |
| w any | | 10a. State 10b. County | | | • | Town or L | ocation. | | | | | | | | | 10d. Inside City Limi | - 1 |
| yland | 흱 | MD Cecil 10e. Street and Number | | | Elkt | ton_ | 110 | Of. Zip Coo | ie . | | | | 10a C | tizen of Wha | | | 40 |
| eath with the Maryland items 23a or 28a-f show ust be notified at once. | Director | 421 Pulaski Hi | .ghway #9 |) | | | | 1921 | | | | | USA | | | .,, | |
| ms 23. | — L | 11. Marital Status | | Decedent I d Forces? | Ever in U. | .S. 13 | | | | | | cify Yes or Nican, etc.) | No- | 14. Race - White, | | an Indian, Black, | |
| or ite | Ĕ | 1 X Never Married 2 M | 1 X Y | s 2 | No | | | | | | ueno n | dcari, etc.) | | | Whi | to | |
| urs afte | 2 | 3 Widowed 4 Di 15. Decedent's Education (Sp | vorced If Yes, Give or Dates: ecify only highest | grade com | 32_8 <i>6</i> pleted) | 16a. Dec | _ | es 2 X Usual Occi | | | nd of wo | ork done | 16b. | Specify: Kind of Busi | | | |
| 72 hor | 활 | Elementary/Secondary (0-12 | | e (1-4 or 5 | | l | - | of working | life. D | O NOT us | se retire | ed) | | | | | |
| 5-0036 led within 7 Hygiene. lother than | Completed | 12 17. Father's Name (First, Middle | 1 0 | | | Elec | tric | rian | 140 | Mathada | N / | Ciast Mindala | | onstru | icti | on ————— | |
| | ပ် ရှိ | Charles Dee Ha | | ā. | | | | | | | | First, Middle Kubiał | | n Surname) | | | |
| 2. 3 % 2 8 1 | | 19a. Informant's Name/Relation | | | | | | | | | | | | City or Town | , State, | Zip Code) | |
| alth 2 | | Theresa Harris | s/motner | | 20b F | DD4 Place of D | | | | | | ia, MI | | U44 Location - 0 | City or 1 | own State | _ |
| Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N important: If item 27 is in injury or other traumant. | | 1 Burial 2 X Crematic | | al from Sta | te c | crematory | or other | place) | | · | , no | /21/12 | | oodbir | · | | |
| Baltimore permit. Pages 1 Department of Important: of injury or other | ŀ | 4 Donation 5 Other 5 21. Signature of Funeral Service | | | LII | | | | | | | | | P.O. | | | \dashv |
| per Deprin | | Devel & He | litte | | MO1 | 1251 | Beve | erly I | J1 | Heckr | ott | e, P. <i>l</i> | 4. C | larksv | <u>rill</u> | e, MD 210 |)29 |
| Physician / <u>M</u> edical | I | 23a. Part I. Enter the disease, of failure. List only one caus | | at caused t | the death. | . Do not er | nter the r | mode of dy | ving, su | uch as care | diac or | respiratory a | arrest, si | nock, or hear | t | Approximate Interv Between Onset ar | |
| iner | | Immediate Cause (Final diseas or condition resulting in death) | a. Pneur | | quence o | rf): | _ | | | | | | | | _ | Death | _ |
| | J | Sequentially list conditions, | b | | 11 | | | | | | | | | | | | |
| | 힅 | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated | Due to (or | as a conse | quence o | f): | | | | | | | | | | | |
| ted Insit | Examine | events resulting in death) Last | Due to (or d. | as a conse | quence o | f): | | | | | | | | | | | |
| be executed incian and untal - transit | dical | X UNPENDED | | _D 23a, | 27,p | er me | e,g9 | 27 5- | -3-1 | 2 sm | | | | | | | \exists |
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| Box 68760 e death certificate the attending physicol for use as the bu | 흥 | past 12 months? | 4 P | ve birth regnant at t | time of de | ath 5 | Fetal | death (Specify) | 3 | _Ectopic p | regnan | icy | | Month | D | ay Year | |
| Box ne death c the atten | Physi | | | nknown | | | | | | | | | \perp | | | () 100 | |
| P. P. S. that | 2 | Part II. Other significant cond | tions contributii | ng to death | but not re | esuiting in | tne una | enying cau | ıse gıv | en in Part | I, | | | | | ne cause of death? | |
| ords, w require s been sig | Completed | - | | | | | - | | | | | 24a. Wa | | | | opsy findings availal | |
| of Vital Records, ig Physician: The law require After this certificate has been similared director, page 2 should the | 틽 | | | | | | | | | | | per | opsy formed 2 | ? de | eath? | ompletion of cause o | TC |
| | B B | 25. Was case referred to medic | | ., | | | | 26.P | lace o | f Death (C | heck or | | | | V 10. | , | |
| Physici r this c | ટ | examiner? 1 ✓ Yes 2 No | Hospital: 1 | Inpatier | | ER/Outpa | | | | | | Home 5 | | dence 6 🗸 | | Scene | |
| - 3 . ~ 2 | | 27. Manner of Death 1 X Natural 5 Per | iding 28a. L | ate of Injur | ry ear) | 28b. Tim | e of Injui | ` I . | _ | at Work? | | 28d. Describ | e now ir | njury occurre | a | | |
| Division tal or Attendi us after ceath. al Director: A | [2 | | estigation 28e. I | Place of Inj | ury - At h | ome, farm, | street, f | factory, offi | ice bui | Iding, etc. | 1 | | | and Number | r or Rur | al Route Number, C | ity |
| Div pital o ours af ceral D | Certification | 4 Homicide | ermined (Spec | cify) | | | | | | | | or Town | , State) | | | | |
| | | | Physician: To the aminer: On the ba | | | | | | | | | | | | | | |
| To To Com | Medical | 29b. Signature and title of certif | and mann | er stated. | | | | | | number | | | | | | th, Day, Year) | |
| | | D-~ | | | | | | 0 | .C.M | .E. | | | Fe | bruary 20 | , 201 | 2 | |
| 10K | ŀ | 30. Name and address of person | | | | | 00014 | / D-III: | | Name -4 = |) _ li. | | 14000 | | | | |
| · Nr / | ifa | Donna M. Vincenti, N 31. Date filed (Month, Day, Year | | nt Medic . Registrar | | | SOO W | . Baitim | ore S | orreet, E | altım | ore, MD 2 | 1223 | | | | |
| Registr | rar | FEB 2 2 2012 | Beauca | A. | 10 | A Contraction | | | | | | | | | | | |

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amend 26, per phy g924 2-22-12 sm
State of Maryland / Department of Health and Mental Hygiene

| | | | For State Registrar | | State of I | viaiyiaii | | tificate of | | and iv | , | Reg. N | | | | | | | | | |
|-------------------|---|-------------------|---|--|--|--------------------------|------------------------------|---|--------------------|--------------------------|----------------------------------|----------------------|--------------------------------|---------------|------------------------------|------------------|--|--|---|------|----|
| | Physicia | in/ | 1. Decedent's Name | First, Middle, Las | t) | | | _ | | | 2. Date of De Month | ath | ZU | 12 | 3. Time of | Death 0 | | | | | |
| Medical Examiner | | | Mary Lou Harbaugh | | | | | Februa | | | | | y 16, 2012 2:16 P ^M | | | \mathbf{P}^{M} | | | | | |
| | | | 203 Sava | | street and number, |) | | 4b. City, Town, o | | of Death | | | c. County | | | | | | | | |
| | Funeral | | 5. Social Security Nun | nber 6. Se | ex 7. A | Age (In yrs. la | ast birthday) | Frede: | If Under | 24 Hrs. | 8. Date of Birl | | Frede | | lace (State o | or Foreign | | | | | |
| b | Director | | 213-22-30 Usual Residence of | | □м2ѬॄF | 84 | Yrs. | Months Days | Hours | Min. | (Month, Da Mar 22 | y, Year) | 927 | Count Mary | ry) | i i oroigii | | | | | |
| | land show | ţ | 10a. State | 10b. County | | 10c. City | , Town or Loc | ation | | | | | | 10 | Dd. Inside Ci | ty Limits | | | | | |
| | Mary 28a-1 otifie | Director | | Allegany | | Cumb | erland | | | | | | | | 1 X Yes | 2 🗌 No | | | | | |
| | s 23a or | Funeral D | 10e. Street and Numb 819 Bedfo | | t | | | 10f. Zip Code 21502 | | | | 10g. C USA | itizen of W | hat Count | ry? | | | | | | |
| 980 | 72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at | 2 | 11. Marital Status 1 ☐ Never Married 3 🗶 Widowed 4 | | 12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates. | ? | 1 | /as Decedent of H Yes, specify Cub | | gin? (Spec , Puerto F | cify Yes or No- Rican, etc.) | - 1 | | - America | tc. | | | | | | |
| 21215-0036 | 72 hour n "natu /edical | Completed | (Special | 15. Decedent's Ed fy only highest gra | lucation | | (Give k | ent's Usual Occup ind of work done | durina most | of working | ig . | | Kind of Bus | | | | | | | | |
| 1212 | iled within I Hygiene. other thai rent, the N | Be Cor | Elementary/Second | | College (1-4 or | r 5+) | Homem | NOT use retired, aker | | | | Own | n Hom | e | | | | | | | |
| /lanc | ould be file nd Mental H marked of matic ever | To B | 17. Father's Name (Fir. Martin J. | | | | | | | | (First, Middle, Hughes | | Surname) | | | | | | | | |
| , Maryland | 2sh thai trau | | 19a. Informant's Nam Elizabeth | | | ıter | | g Address (Street avage Ro | and Numbe | r or Rural | Route Number | r, City oi | | ate, Zip Co | ode) | | | | | | |
| Baltimore, | permit. Page 1 and Department of Heali Important: If item 2 any injury or other once. | | 20a. Method of Dispos 1 ☐ Burial 2 X 4 ☐ Donation 5 | | Removal from Stat | e ce | emetery, crem | ition (Name of atory or other plai rney Cre | | | rate '20/12 | | ocation - 0 | - | | | | | | | |
| Balt | permit. Depart Import any inj once. | | 21. Signat of Funer | ral service Licens | 0 11 | | G O | Name and Addre | ss of Facility | ation | Servi | ce | P.O. | Box | 784 | | | | | | |
| | | | 23a. Part 1. Enter the | disease, or comp | lications that cause e cause on each li | MO12 | . Do not enter | verly L. the mode of dyir | Hecking, such as o | cotte cardiac or | respiratory arr | -Cla est, | irksv. | 11.00 | Approximate | е | | | | | |
| part. | Physician/ Medical | 0 1 | Immediate Cause (Fir disease or condition resulting in death) | | a. POST Due to (or as | RA | | 4011 | cin | aHI | osis | | | | Interval Bety Onset and D | Death | | | | | |
| | Examiner | ler | ıer | ler | ıer | ler | Jer. | Sequentially list cond | itions, | 6AS | Taic | | Lym? | Hov | nP | | | | 1 | 0 41 | rs |
| | cuted nd transit | Examine | Sequentially list cond if any, leading to immediate. Enter Underlyi Cause (Disease or injuthat initiated events | ediate ng ury | Due to (or as a consequence of): | | | | | | | | | | | | | | | | |
| 0 | be exec sician a | | resulting in death) Las | st L | Due to (or as | a conseque | ence of): | | | | | | | | | | | | | | |
| 68760 | ificate ng phy as the | Med | IE EEMALE. | | u | | | _ | _ | | | - | | \perp | | | | | | | |
| . Box 6 | Hospital or Attending Physician: The law requires that the death certificate be executed the bours after death. Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pre in the past 12 mo 1 ☐ Yes 2 ☑ 9 ☐ Unknown | eths? | 3c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown | 2 Fetal at time of de | death 3 🗌 | Ectopic pregnand Other (specify) _ | су | | | | 23d. Date Mont | | - | 'ear | | | | | |
| , P.O. | requires that the des been signed by the s should be detached | ρ | Part II. Other significa | ant conditions co | ntributing to death | but not resu | Iting in the un | derlying cause gi | en in Part I. | | | | | | cause of de | | | | | | |
| Records, | require been si should | leted | | | | | | | | | 1 □ Y | | | | ably 4 🗆 U | | | | | | |
| Rec | sician: The law is certificate has k | Completed | | | | | | | | | autop | sy med? | pri de | | pletion of ca | | | | | | |
| ţa | ysician: s certific director, | m | 25. Was case referred to examiner? 1 Yes 2 | | lospital: | | | 26. Pl | ace of Death | (Check o | | | | | aught | er's | | | | | |
| of < | ding Phys th. After this funeral di | e : | 27. Manner Death | 10 | 1 Inpat 28a. Date of inj | ury 2 | R/Outpatient 28b. Time of | 3 DOA 28c. Injun | 4 ∐ Nur | sing Hom | | | | (Specify | ome | | | | | | |
| ion | ttending death. tor: After | Certificate: | 1 Matural 5 Death Injury 1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be | | | | | | | | | | | | | | | | | | |
| Division of Vital | pital or Ai burs after eral Direc filled in by | | 4 Homicide | determined | | tc. (Specify) | | • | | | 3f. Location (St City or Town | n, State) | | | | er, | | | | | |
| | he Hosp in 24 hos he Fune pletely fi | Medical | (Check 2 🗆 | Medical Examin | cian: To the best o er: On the basis of Practitioner: To the | examination a | and/or investic | ation, in my opinic | n, death occ | urred at th | ne time, date an | nd place | and due to | o the caus | e(s) and man | iner stated. | | | | | |
| | To the within 2 To the comple | | 29b. Signature and title | | 104 | | | 29c. License | | | | | e signed (/ | Month, Da | ıy, Year) | | | | | | |
| | | | 30. Name and address | of person who co | mpleted cause of a | | 23a) (Type, Pri | | 8171 6170 | | | 41 | | 201 | | | | | | | |
| | | | JULIO MI | SHOCK | mD 11 | O BAU | Glam | | | 14 | IFRE | Nic | 4 ~ | -0 | ていて | 2 | | | | | |
| | State Registra | | FEB 2°2'2 | 012" | 32. Registr | ar's Signatur | Kel | | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 228 P PONALD 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 127 Seneca Shore Road Cecil Perryville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 217-40-9541 1 XM 2 □ F 67 NOV-17, 1944 Maryland Usual Residence of Decede ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cecil MD Perryville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 127 Seneca Shore Road 21903 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Yes, Give 10 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 1967-69 Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Financial Planner Financial Planning permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy, Important: If Item 27 is marked other any injury or other traumout? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Charles Harrington Chenoweth Eula Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 Seneca Shore Road Jane E. Harrington, wife Perryville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/21/12 Baltimore, MD 21. Signature of Funeral Service Licensee MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical [']Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DDA 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pendina work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Afted in by the fur Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in k Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ap 29c. License number

3 11

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Vital

Division of

State Registrar

| | | | 1 - For Amend Ite Registrar | m 25 State of per me | Maryland , g925 | d / Dep 02 / 21 / Ce/ | artment of 2012dhb | Health | and N | /lental Hy | giene | 10 | 01.050 | |
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| | | , | Decedent's Name (First, Middle, Last) | | | | | | 2. Date of De | ate of Death 3. Time of Death | | | | |
| | Physicia Medi | | James Haynes | | | | | | | Febru | ary 19 | 2012 | 437 AM | |
| | Examir | ner | 4a. Facility Name (if not institution | ^ \ | 4b. City, Town | | | 4.3 | 4c. County | of Death | | | | |
| | Funeral | | 5. Social Security Number | | Age (In yrs. la | | If Under 1 Year | ar If Unde | er 24 Hrs. | 8. Date of Bir | | 9. Birthp | olace (State or Foreign | |
| | Director | | 418-28-6793 | 1 🔀 M 2 🗆 F | 91 | Yrs. | Months Day | s Hours | Min. | (Month, Da | y, Year) 23,1920 | Coun | | |
| \ | Show | 5 | Usual Residence of Decedent 10a. State 10b. Coun | ty | 10c. City | , Town or Lo | cation | | | | , , , , , | | 0d. Inside City Limits | |
| | Marylg 28a-f | by Funeral Director | Md. Ba | ltimore | | | Dundalk | | | | | | 1 🗆 Yes 2 🔀 No | |
| | th the | alD | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citizen of \ | What Coun | try? | |
| | ath wi | nuei | 7005 Fait A | 12. Was Decede | ent Ever in IIS | 13 1 | Vas Decedent of | 21224 | rigin? (Spe | scifu Voe or No | $\overline{}$ | JSA | | |
| 215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance. | | 1 Never Married 2 Min 3 X Widowed 4 Divorce | Armed Force | es? | l1 | Yes, specify Cu | ban, Mexica | n, Puerto | Rican, etc.) | Blac | e - Americ ck, White, e Whi | etc. | |
| 15-0 | 72 hou n "natu edica | Completed | | ent's Education hest grade completed) | | (Give I | lent's Usual Occ | e during mo: | st of worki | ng | 16b. Kind of B | usiness/Inc | dustry | |
| 212 | vithin in interest. In that the Market | Con | Elementary/Secondary (0-12 12 years | College (1-4 | or 5+) | life. DO | NOT use retire Labore: | / | | | Die | still | orv | |
| | filed wal Hyg | Be o | 17. Father's Name (First, Middle | Last) | | | | T | her's Name | e (First, Middle, | Maiden Surname | | CL y | |
| ylaı | Ment Marker narker | 은 | Lawrence H | | | | | | Flo | rra Lin | dsey | | | |
| , Maryland | id 2 shoresalth and n 27 is ner traum | | 19a. Informant's Name/Relation Bonnie Haynes | | er | | | | | | r, City or Town, S , Md. 21 | | ode) | |
| nore | age 1 and nt of Hea t; If item | | 20a. Method of Disposition 1 Burial 2 Cremation | | ate ce | metery, crem | sition (Name of natory or other p | | Febr | | 20c. Location - | • | , | |
| Baltimore, | permit. P Departme Importar any injur | | 4 ☐ Donation 5 ☐ Other 21. Signature ☐ ☐ ☐ Service | | 1 0 0 0 | | Cemete | - | 22, ; eral 1 | 2012 Home of | Dundalk | | | |
| | E0 = 0 0 | | 23a. Part 1. Enter the disease, on shock, or heart failure. List | Complications that cau | sed the death. | not ente | 7110 So | llers | Poin | Road, | Dundalk Dundalk | , Md | 21222 Approximate | |
| -~ | Ph_sician/ | | Immediate Cause (Final disease or condition | | ¥ 0,000 as | | , | | | | | | Interval Between Onset and Death | |
| - Single | Medical Examiner | | resulting in death) | | as a co eque | | И о мо | است | - 0 0 | م ا | 1 | . 1 | | |
| | si; d | Examiner | Sequentially list conditions, if any leading cause. Enter Underlying | b. One to (se | b. Intracranial Hemorrhage C. Due to (or as a consequence of): d | | | | | | | | | |
| | ate be executed ohysician and the burial-transit | Exar | Cause (Disease or injury that initiated events resulting in death) Last | as a conseque | ence of): | | | 0 | 1 A N | COICAL EXAMINE | | | | |
| 09 | te be e nysicia he bur | edical | | d | | | | | 1 | N PPROVED BY | | | | |
| 687 | attending pl | /Me | IF FEMALE: | 23c. If yes, outcor | no of prognan | 0.1 | | U | PATEION | | | | | |
| Box | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 1 ☐ Live Bir 4 ☐ Pregnar | 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | | | | | | 23d. Dat Mor | e of deliver | ry Day Year | |
| s, P.O. | res that I signed b | by | Part II. Other significant condit | ions contributing to deat | death but not resulting in the underlying cause given in Part I. | | | | | | Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown | | | |
| of Vital Records, | v requires the been signer should be | Completed | | | | | | | | 24a. Was a | | | sy findings available | |
| Rec | The law ate has page 2 | Som | | | | | | | | autop | rmed? p | rior to con leath? | npletion of cause of | |
| ta | ysician: The s certificate director, pag | Be | 25. Was case referred to medica examiner? | Hospital: | | | | Place of Dea | ith (Check | | 2 2 3 10 1 | | | |
| ₹ V | S S | 으 | 1 A Yes Z No 27. Manner of Death | 1 XJnp | niury 2 | R/Outpatient | 3 ☐ DOA Ot | | | | ence 6 Othe | | | |
| o uc | Attending Physician: rr death. sctor: After this certific by the funeral director. | icate | 1 Natural 5 Pend | | Day, Year) | injury | wo | rk? ☑Yes 2 ☐ | 1 | 8d. Describe h | ow injury occurre | d | | |
| Division | l or Atten after deat Director: I in by the | Certificate: | 3 Suicide 6 Could 4 Homicide determ | not be nined 28e. Place of building, | Injury - At hom etc. (Specify) | ie, farm, stre | et, factory, office | | 2 | 28f. Location (S. City or Town | treet and Numbe n, State) | r or Rural F | Route Number, | |
| | To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral | Medical (| (Check 2 L Medical | g Physician: To the best Examiner: On the basis of | of examination a | and/or investi | gation, in my opir | iion, death o | courred at a | the time date ar | nd place, and due | to the caus | se(s) and manner etated | |
| | To the within 2 To the complet | Ž | only one) 3 L Certifyin 29b. Signature and title of certifie | g Nurse Practitioner: To | the best of my | knowledge, | death occurred at 29c. Licens | the time, da | te and plac | ce, and due to the | ne cause(s) and m 29d. Date signed | anner as st | ated. | |
| 0 | | | P W | | | | | 5-0 | 00 | F | ebruc | ry | 19 2012 | |
| _ | | | 30. Name and address of person Wan - Tsu Cu | | | | | Stra | et (| | ore m | | | |
| | Stat Registra | - 1 | 31. Date filed (Month, Day, Year) FEB 2 2 20 | 32. Regis | strar's Signatur | face | | | | | | | | |

DHMH 17 Rev 06-2011

12-01447 Mark Vincent Jones

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| | State of Maryland / Department of Health and Mental Hygiene |
| | State of Marviand / Department of Health and Mental Hydreffe |

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| hark vincent Jones | 1- For State 1- For State Certificate of Death Registrar | Reg. No. | |
|--|---|---|--|
| Physician/ | Decedent's Name (First, Middle,Last) | Date of Death Month Day Year February 18, 2012 | 3. Time of Death 1702 hrs |
| Medical Examiner | MARK VINCENT DONES 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death | 4c. County of Deat | |
| 1 | 3701 Twin Lakes Court Windsor Mill | Baltimore Co | |
| Funeral Director | 139-68-1140 11/M 2 F 45 Yrs. Months Days Hours Min. | 8. Date of Birth(MM/DD/YYYY) 9. Bit APR, 8, 1966 Co | |
| ow any | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | 10d. Inside City Limits |
| the Maryland a or 28a-f shu tified at once Director | 10e. Street and Number 10f. Zip Code | 10g. Citizen of What Cou | intry? |
| ith the N 23s or 23s or al Dir | 120 8 BAN more By unit 7 21842 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec | W, SA | rican Indian, Black, |
| e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I tem 27 is marked other than "matural", or items 23a or 28a-f she or traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director | 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri | | Ack |
| nours aft. | lor Dates: | k done 16b. Kind of Business/ | /Industry |
| 5-0036 ed within 72 hours tygiene. other than "natur the Medical Exam Completed I | Elementary/Secondary (0-12) College (1-4 or 5+) ARADISE PLAZA TAN | V MAN | AGER |
| ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica To Be Comple | WARREN KiCHARD JONES SP. BANDR | First, Middle, Maiden Surnapre) A LEE TALL | |
| MD 21 d 2 should th and Me a 27 is ma umatic ev | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur | ral Route Number, City or Town, State | e, Zip Code) 21244 |
| ore, MC es I and 2 si of Health ar If item 27 iher trauma | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, or crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cremation 3 Removal from State Cremation 3 Removal from State Crematory or other place) 1 Cremation 3 Removal from State Crematory or other place) 1 Cremation 3 Removal from State Crematory or other place) 1 Cremation 3 | Date 20c. Location - City or | r Town, State |
| Page Page | 4 Ponation 5 Other Specify: GREF Nynount CEM 2/2 | 1/2012 BAHO. | md |
| Balti permit. Departu Importi injury c | I leve warms was 1844 N ARDAQWA | | 2/2/3 |
| Physician /Medical | 2/a. Firt I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovas | | Approximate Interval Between Onset and Death |
| Examiner | Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovas Due to (or as a consequence of): | culai Disease | |
| iner | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause | | |
| tred ansit | (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. | | |
| 60, ate be execut hysician and te burial - tra | ☑ UNPENDED ☐ AMENDED 23a,pt.II,27,per me,g925 3-1-12 | sm | |
| Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. The law requires that the death certificate be executed the Funeral Director: After this certificate has been signed by the attending physician and applietly filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Physician/Medical Exilical Certification: To Be Completed by Physician/Medical Exilical Certification: To Be Completed by Physician/Medical Exilical Certification: To Be Completed by Physician Physician Exilical Certification: To Be Completed by Physician Physician Exilical Certification: To Be Completed by Physician Physician Exilication Physician Physician Exilication Physician Ph | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) | 23d. Date of deliver Month | Day Year |
| Box ne death the atte | 1 Yes 2 No 9 Unknown 9 Unknown | 23e. Did tobacco use contribute to | the cause of death? |
| ires that the signed by vibe detach | | | bably 4 V Unknown |
| Records, P.(The law requires that ficate has been signed page 2 should be det Completed by | | autopsy prior to performed? death? | utopsy findings available completion of cause of |
| tal Rectan: The certificate ector, page | | 1 ✓ Yes 2 No 1 ✓ Y ly one) | es 2 No |
| f Vital Physician or this cert ral directo | 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 4 Nuising | Home 5 Residence 6 ✔ Othe | er: Scene |
| on of ending Plath. or: After the funera | | 8d. Describe how injury occurred | |
| Division of Vital Records, P.O. ital or Attending Physician: The law requires that th ars after death. ral Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detach entification: To Be Completed by P | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 8f. Location (Street and Number or R or Town, State) | ural Route Number, City |
| Division of Vital Records, To the Bospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been seconpletely filled in by the funeral director, page 2 should Medical Certification: To Be Complete | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and do one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tand manner stated. | ue to the cause(s) and manner as sta he time, date and place, and due to t | ited. he cause(s) |
| To To Nec | 29b. Signature and title of certifier 29c. License number O.C.M.E. | 29d. Date signed (Mo | |
| | 30. Name and address of person who completed cause of death (Item 23a) | 1 Gordary 19, 20 | |
| φ | Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, N | /ID 21223 | |
| State Registra | 31. Date filed (Month, Day, Year) 32. Registrar's Signature FFR 9. 2 2012 | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JONES Month 0 2 Yea 200AN 0 012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death NUBSING DAILMORE NIA If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 🗆 F (Month, Day, Year) Country) Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State ural", or items 23a or 28a-f sho Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral Matthewo 21202 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates Specify: "natural", Black Completed 3 Widowed 4 Divorced Specify: permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothu lone 19a. Informant's Print (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Himore MD 21202 Baltimore, . Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March FlH-East 1101 E. North MN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on ea Interval Between Immediate Cause (Final disease or condition Onset and Death ENdSLAGE UNGCUING ACCIDENT WICH A Physician/ CEREBBAI Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 ☐ Yes 2 🗓 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 Tyes 2 No Other: 1 Inpatient 2 I Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA filled in by the funeral Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Natural (Month, Day, Year) 5 Pending 1 🗌 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 4 Homicide City or Town. State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie (Check 29b. Signat d title of certifier 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Regi

han Woods

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Registrar Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death January 2 2012 ar Physician/ 03:03 Johnson R. Kevin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Days 1 X M 2 🗆 I Months 57 Director 273-54-1198 Ohio 9/26/1954 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f shormust be notified at filed within 72 hours after death with the Maryland Director Maryland | Prince George's Temple Hills 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20748 4306 Townsley Avenue ural", or items ? I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXNo
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baggage Handler 12th grade permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Bernice Rogers Walter Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 4306 Townsley Avenue Temple Hills, Maryland 20748 Bernice Johnson (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Suitland, Maryland Wash. National Cemetery 1/6/2012 4 Donation 5 Other (Specify) 21. Signature of Furieral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home of Maryland 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Complications of Hemorrhagis Cerebrovascular Impediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final - Accident Pnysician Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of) Cause (Disease or linjury the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) 0 Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the atte should be detached for 5 Other (specify) Pregnant at time of death g | I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? by Diasetas Melli tue 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Renal Failure performed 1 🗌 Yes 2 🗆 No VENTOLOTO 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XYes 1 Inpatient 2 X ER/Outpatient 3 IDOA ပ္ this funeral 28a. Date of injury (Month, Day, Year) n 24 hours arter uea.... ne Funeral Director: After th neted filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Recruifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 3, 2012 D01852 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ad Hyattsville MD 20781 4202 Queenshum

Registrar

31. Date filed (Month, Day, Year)

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me, g924,02/15/2012dhb
Certificate of Death
Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:20 AM)ones 2012 nthia Medical 4c. County of Death Baltimore Facility Name (if not institution, give street and number **Examiner** Randallstown City, Town, or Location of Death yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min (Month, Day, Year Country) 1 🗆 M 2 📈 **Director** 13 ice of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Baltimore 28a-f MD 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 ms 23a or must be n Stricker Funeral 321 USA 21223 items ? Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) sabled Be 17 Father's Name (First Middle Last. 18, Mother's Name (First, Middle, Maiden Surname) ည lonesJR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McCoy Stricker St. Balto mo alazz loanne 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Glen Burnie, MD)An. 26,2012 4 Donation 5 Other (Specify Calvary 21. Signatu 70 Fredhilton Pass Balto MD 21229 23a. Part / Enter the dis shock or heart failu Immediate Cause (Final Enter the disease, or complications that caused the death. Do not enter the mode of dying or heart failure. List only one cause on each think. Approximate Inter al Between and t Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) AL EXAMINER attending physician and for use as the burial-transit CERTIFIC TION APPROVED BY Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the at I be detached fo signed by Part I/ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ *Wn 1 Yes 2 10 3 Probably 4 Unknown Completed should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 No ate has bage 2 s 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Conflying Nurse Prantitioner: T. If no one of my homogo, death occurred at the time, date and place, and due to the cause(s) and manner stated Conflying Nurse Prantitioner: T. If no one of my homogo, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b, Signature, and title of 29c. kicense numbe 29d. Date signed (Month, Day, Year)

232

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

MEDU 17

31. Date filed (Month, Day, Year)

JAN 25

835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland / Department of Health and Mental Hygiene reg. No. 27.16/2012dhb Certificate of Death Reg. No. No. 29. No. 2012 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:21 ACKSON 2012 Medical an very City, Town, or Location of Death Facility Name (if not institution, give street and number) **Examiner** 4c County of Death Medical XKN BURNIE ENTER INNE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Security Number Months Days Hours Min. Country) 214-78-0459 55 **Director** MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2XXNo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 210 Main Ave 21061 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2XX Married Yes 2XXNo コキcKso人, J*Ames ト* Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Specify: White "natural" 3 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver 10 Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lemue1 Ε Jackson Ruth Leadmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Donna Jackson / Wife 210 Main Ave Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2012 Glen Burnie, MD <u>Glen Haven Mem. Park!</u> 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) hours Medical equence of): Examiner Trointestine da Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): artending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ysician/Medical Division of Vital Records, P.O. Box 68760 CERTIFIC IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Pregnant at time of death Day hed t Unknown 9 Unknown ā Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been signer ral director, page 2 should be de Completed by carcinama 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yes 2 N 2 No 1 Yes completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 68240 ess of person who completed cause of death (Item 23a) (Type, Print) Hos ork

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Irene Junga 12:20 PM February 16, 2012 Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Days Months 165-26-6706 Usual Residence of Decedent 1 🗆 M 2 🔀 F May 24, 79 1932 Pennsylvania 10c. City, Town or Location 10d. Inside City Limits Bethesda Montgomery 1 ☐ Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6530 Democracy Blvd. 20817 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ira Elwood Shaw Guyla Blanche Hockenberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Lanzetta/daughter 23023 Schoolcraft St. West Hills, CA 91307 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 D Cremation 3 D Removal from State Final Journey Crematory 02/18/12 4 Donation 5 Other (Specify) Woodbine, MD

Ph_sician Medical **Examiner**

attending physician and I for use as the burial-tran

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To the Hospital or within 24 hours at To the Funeral D

requires that the death certificate be

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

= State Registrar

Agnes

10a. State

MD

Physician/

Medical

Examiner

Funeral

Director

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al Hygiene. d other than "natura event, the Medical E

Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic evenoce.

Director

Funera

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Completed

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21. Signatur of Funeral Service Licensee

| | Devent I ti | Going Home Cremation Beverly L. Heckrotte | n Service P.O. Bo P.A. Clarksvill | x 784 e. MD 21029 | | | |
|---|---|---|--|--|--|--|--|
| | 23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) | olications that caused the death. Do not enter the mode of dying, such as cardiac or | | Approximate Interval Between Onset and Death | | | |
| Completed by Physician/Medical Examiner | Sequentially list conditions, if a ry, bedding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Cus to (or as a consequence of): C. Due to (or as a consequence of): | | | | | |
| ysician/med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No g □ Unknown | 23c. If yes, outcome of pregnancy 1 | 23d. Date of del Month | ivery Day Year | | | |
| ed by Pr | Part II. Other significant conditions of | ontributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to 1 ☐ Yes 2 🎗 No 3 ☐ Pr | | | | |
| Complet | | | autopsy prior to or performed? performed? | topsy findings available completion of cause of | | | |
| ge | 25. Was case referred to medical examiner? | 26. Place of Death (Check of | only one) | | | | |
| 0 | 1 Tes 2 No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom | ne 5 Residence 6 X Other (Speci | hospice | | | |
| ricate: | 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation | 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 \sum Yes 2 \sum No | 8d. Describe how injury occurred | | | | |
| edical Certificate: 10 | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 8f. Location (Street and Number or Rui City or Town, State) | er or Rural Route Number, | | | |
| Medica | (Check 2Medical Exami | ician: To the best of my knowledge, death occurred at the time, date and place, and ner: On the basis of examination and/or investigation, in my opinion, death occurred at the Practitioner: To the best of my knowledge, death occurred at the time, date and place | he time, date and place, and due to the o | cause(s) and manner stated | | | |

29c. License number

R143201

29d. Date signed (Month, Day, Year)

February 16, 2012

22. Name and Address of Facility

DHMH 17 Rev 06-2011

State Registrar Debrah Miller, CRNP 6001 Muncaster Mill Rd. Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #3 state of Waryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12;34pm M Physician/ JEFFREY KAYE **FEBRUARY** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SUBURBAN HOSPITAL **BETHESDA** If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Months Hours Min (Month, Day, Year) **Director** 153-48-5417 1 🗶 M 2 🗆 F 57 07/18/1954 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MONTGOMERY CHEVY CHASE MD 0 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ns 23a c must b pe Funeral 4611 MORGAN DRIVE 20815 USA 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. or by 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) l Hygiene. 27 is marked other that traumatic event, the JOURNALIST JOURNALISM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F t. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o ပ KAYE HENRIETTA WILLIAM HAMBURGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALEXANDRA KAYE / WIFE 4611 MORGAN DRIVE, CHEVY CHASE, MD 20815 20a. Method of Disposition
1 □ Burial 2 🖾 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION, INC 02/16/2012 HAMPSTEAD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ARTERIOSCLEROTIC HEART DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical as t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 X No death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospita Other: 2 🛚 No 1 🗌 Yes မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, Division of 27. Manner of Death 28b. Time of 28a. Date of injury 28c, Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) 24 hours a Funeral L Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 8600 OLD GEORGETOWN ROAD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

32. Registra

BRENDON CARMODY,

D055480

2/11/2012

BETHESDA, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month W. Gail Kline 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. last bir If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 218-32-6939 1 🕅 M 2 🗆 F 72 3/6/1939 MD Usual Residence of Decede 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director 1 Yes 2 X No MD Carrol1 Mt. Airy 5 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 4650 Roop Rd. 21771 USA items 2 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces:
1 X Yes 2 [
If Yes, Give Black, White, etc. jo, þ 1 Never Married 2X Married 2 No 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 'natural" Completed 3 Widowed 4 Divorced If Yes, Give Year or Dates. 1978–84 White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Avionics Communication Tech. U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gail Wesley Kline, Sr. Ella E. Lind 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. W. Gail Kline/Wife 4650 Roop Rd., Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Pleasant Ridge Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2/23/2012 Winfield, MD Signature of Auneral Service Licenses 22. Burrier of early Funeral Home & Crematory, P.A. any 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sirock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death ete cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner nat failure Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. arters pronoru and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy page 2 should be detached for in the past 12 months? Month Pregnant at time of death Dav Other (specify) Year 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown mellitus COPD peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteomelitis After this certificate has autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No ours after death.

eral Director: After this certifical filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 06-2011 Relecco Eles

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c License number

100484

22 South Greens

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year Bernice Kappes 12 30 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Sauare Baltimore HOSPITEL Rosedale 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 220-18-7359 Director 1 □ M 2 🔀 F 84 April 12,1927 Maryland Usual Residence of Dec 10a. State 10b. 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director or 28a-f sl Md. Baltimore Dundalk 1 Yes 2 No 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 7525 Durwood Road 21222 "natural", or items edical Examiner mu death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. by 1 Never Married 2 Married Yes 2 No Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 21215-0036 1 Yes 2X No Specify: White If Yes. Give Specify: 3 ⋈ Widowed 4 □ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Junior Accountant 12 years **USFG** Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Kucharski Mary Rostowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Linda Dannenfelser 27 Daughter 1915 Bachman Valley Road, Manchester, Md. 21102 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Februäry cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 4 Donation 5 Other (Specify) 23, 2012 21. Signatu of Funeral Service Lic 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, 401176 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Hypoxia disease or condition Medical resulting in death) Due (or as a consequence of) **Examiner** potension HY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Examine Due to (or as a consequence of): Decompensated Heart Failure
Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No After this certificate has autopsy performed Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No မ 1 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No.

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

within 24 hours after deatl To the Funeral Director:

State Registrar

Medical

DR Dereddi Rava 31. Date filed (Month, Day, Year)

& Paishules

Investigation

determined

6 Could not be

Accident

Suicide

4 Homicide

only one)

29b. Signature and title of certifier

FEB

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shekar Reddy

RESODOO

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9000 FRANKLIN SQUEETE DR BELTO Md Z1237

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Leslie 16 2012 2:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Helmsby Road Catonsville Baltimore Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Country 212-18-8236 Director 1 M 2 X 91 Yrs. 1920 Maryland Oct. 26. Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location notified at 10d Inside City Limits Director 1 🗆 Yes 2 🗐 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? er than "natural", or items 23a o the Medical Examiner must be Funeral 2002 Helmsby Road 21228 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 XNo 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Montegriffo Lydia Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 so it of Health a if item 27 i Michael Leslie / Son 2002 Helmsby Road. Catonsville, Maryland 21228 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 № Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) injury or Department Important: I any injury or once. 02/20/2012 Baltimore, Maryland Lorraine Park Cen. Signature of Euneral Service Licensee Alyson~K~Taylor22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Inset and Death Immediate Cause (Final Youandool Physician/ disease or condition resulting in death) Harved soil Medical to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) tran and that initiated events physician as s the burial-t resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Por in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Pregnant at time of death Day 1 Yes 2 9 Unknown the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ျှ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred eral Director: After filled in by the funer 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 151 ENA 12:50 Medical 12 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8535 Veterans Highway, Unit 118 <u>Millersville</u> _Arundel Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) Director 214-14-1179 1 M 2 89 Yrs. Dec 8, 1922 Maryland Usual Residence of Decedent show Train marked organization in the state of th 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 X No Anne Arundel Millersville 10e. Street and Number 10g. Citizen of What Country? Funeral 8535 Veterans Highway, Unit 118 21108 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Social Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Babka Viola Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Patricia D. Gischel, Daughter</u> 8535 Veterans Highway, Unit 118 Millersville, MD21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 02/22/12 Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc 299 Frederick Road Baltimore, Maryl 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Immediate Cause (Final Physician NEOPLASM GNANT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month 1 Yes 2 No Month Day Year the i 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be director, page 2 s autopsy Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 Yes 2 No Accident Investigation within 24 hours after deal To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one we and title of certifier 118703 22

State Registrar 10

30 Name and address of perso JENEUIEVE

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(Nem 23a) (Type, Print) 45 DEFENSE HWY

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| Baltimore, Maryland 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at | |
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| Division of Vital Records, P.O. Box 68760 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | |
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| | | For | | State o | of Maryland | | | | | and M | lental Hy | /gien | e | 10 | 01.072 |
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| or 28 e not | ä | 10e. Street and Num | | 1111010 | | - Carraci | 10f. Zip 0 | | | | | 10g. (| Citizen of | What Cour | ntry? |
| 23a ust be | era | 4511 Ro | bosson | Rd. | | | 2 | 1133 | | | | | US | A | |
| items er m | Funeral | 11. Marital Status | | 12. Was Dece Armed Fo | edent Ever in U.S | | Nas Decede f Yes, specif | | | | cify Yes or No | - | | ce - Americ | |
| Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | þ | 1 Never Marrie | | ried 1 Yes | 2XXNo | | 1 Yes 2 | | | | ilioan, oto., | | Specify | ck, White, | |
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| artme oortan injur e. | | 21. Signature of Euro | | ice (| Lak | | | | | | | • | | | ory, P.A. |
| lmp any onc | | | NA | Quen- | | 1 | | | | | | | | | D 21784 |
| | | | t failure. List | complications that only one cause on ea | ach line. | | | | g, such as | s cardiac c | r respiratory a | ırrest, | | | Approximate Interval Between Onset and Death |
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| ding I | /W | IF FEMALE: 23b. Was decedent | oragnant | | tcome of pregnar | | | | | | | | 23d D: | ate of deliv | en/ |
| the atten | Physician/Me | in the past 12 n 1 Yes 2 © 9 Unknown | nonths? | | Birth 2 🗀 Feta Inant at time of d nown | | Ctopic pr | | У | | | | | onth | Day Year |
| ed by | by Pl | Part II. Other signifi | cant conditi | ons contributing to c | leath but not resu | ulting in the u | ınderlying ca | use giv | en in Part | t I. | 23e. Did | tobacco | use conf | tribute to t | he cause of death? |
| en sign | | | | | | | | | | | 1 □ | Yes | 2 🗌 No | 3 🗌 Pro | bably 4 Unknown |
| has bee | Completed | | | | | | | | | | | s an opsy formed? | | | psy findings available empletion of cause of |
| ficate or, pag | | 25. Was case referre | d to modical | | | | | 00 51 | | -11- (011 | 1 🗌 Yes | | | 1 🗌 Yes | 2 🗌 No |
| s certi | o Be | examiner? | _ | Hospital: | Inpatient 2 | ER/Outpoti- | at 3 🗆 DO | Othe | r - | ath (Check | me 5 \square Res | idence | 6 🗆 🗠 | or (Canalif | |
| er this | te: To | 27. Manner of Death | _ | 28a. Date | | 28b. Time of injury | | c. Injury | at | | me 5 \square Res 28d. Describe | | | | |
| arn. In: Afte he fur | ertificate | 1 Natural 2 Accident | 5 Pendi | gation | tri, Day, Year) | irijury | М | work | ? Yes 2□ | □No | | | | | |
| Directory in py t | O | 3 ☐ Suicide 4 ☐ Homicide | 6 Could detern | inod 28e. Place | of Injury - At hong, etc. (Specify) | | eet, factory, | office | | | 28f. Location City or To | | | er or Rura | l Route Number, |
| within 24 nours arter death. To the Funeral Director. After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as t | Medical | (Check 2 | Medical I | g Physician: To the b Examiner: On the bar g Nurse Practitione | sis of examination | and/or inves | tigation, in m | y opinio | n, death c | occurred at | the time, date | and pla | ce, and du | ue to the ca | iuse(s) and manner stated. |
| To th | < | 29b. Signature and t | | r | | | 29c. | | number | | | | | ed (Month, | |
| | |) /(| ر(نو | K | ·S·RA | 1-0.M | 0 | D43 | 3462 | | | | 2/21 | /2012 | 2 |
| | | 30. Name and addre | | | se of death (Item | | | Д- | nda1 | l 1 a t a | CAD MID | 211 | | | |
| Stat | e | K.S. Ra 31. Date filed (Month | , Day, Year) | 32. F | Registrar's Signat | ure | 17 201 | , Kč | TRDIII | riero, | wii, MID | | | | |
| Registra | | FEB | 2 2 201 | 2 Bever | legistrar's Signat | park | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George M. Lee Feb 11, 2012 10:30p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Glen Burnie 6654 Roberts Court 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country Director 68 MD 212-44-1391 Jan 1, 1944 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours a er death with the Maryland ıral", or items 23a or 28a-f sho I Ex⊣miner must be notified at Director 1 Yes 2 No Glen Burnie MD **Anne Arundel** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 U.S.A. 6654 Roberts Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify Black "natural" 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Korvette Department Store Employee** ä 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o 2 Laurine J. Lee George T. Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7857 Freetown Road, Glen Burnie, MD 21060 Barbara Moore timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₹ Department of Important: If it any injury or o cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Feb 21, 2012 Pasadena, Md. 4 Donation 5 Other (Specify) Mt. Zion Church Cemetery 21. Signat he of Prineral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21217 23a. Part t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Centr Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has performed Hospital or Attending Physician: The 2 🗌 No 1 Yes 25. Was case referred to ... dical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tyes Other 2 2 🗹 No 1 Inpatient 2 I ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manne eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

600

30, Name and address of person who completed cause of death (Item 23a) (Type, Print

2012

32. Registrar's Sanature

31. Date filed (Month, Day, Year)

DØØ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EDWARD W. LUDWIG Month Year 3:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE CHERRY WOOD CISTERSTOWN BALTIMORE 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🛣 M 2 🗆 F Months Days Hours Min. Director 83 200-22-2837 Marc Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10d, Inside City Limits Director 28a-f 1 Yes 2 to No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11822 Maren Court U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Federal Elementary/Seconday (0-12) College (1-4 or 5+) Government Social Worker 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishered of ၉ Edward Ludwig May Davies 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Edward J. Lee 11822 Maren Court Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Clarks Green Cemetery 4 Donation 5 Other (Specify) 2/24/12 Clarks Summit 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Fundamental Service Licensee ELINE FUNERAL HOME Reisterstown, MD Wayne Osterling 23a Part 1. Due the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MAGIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DEMENTTA Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on: that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death Yes Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 2 100 Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🛂 No Other: 1 Tyes 1 Inpatient 2 Impatient 2 Impatient 2 Impatient 2 Impatient 3 Impa 4 Nursing Home 5 Residence 6 Other (Specify, n 24 hours after deam.

he Funeral Director: After th Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗹 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29c. License number ROSSS52 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith DUSNUE #203 BALTIMONE KIRLY DAL 21209 KATUUSSN C. DIANONS 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

12-01480 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Betty J. Linebarger State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death **Medical Examiner** Betty Jean Linebarger Month Day February 19, 2012 1622 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Randallstown 0 **Baltimore County** 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) if Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 2 X F 212-43-3535 1 M 63 30,1948 Country) April MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once Baltimore Reisterstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Bon Oak Court USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No 3 Widowed If Yes, Give Year 4 Divorced Š 1 Yes 2 X No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry Elementary/Secondary (0-12) during most of working life. DO NOT use retired) College (1-4 or 5+) Baltimore, MD 21215-0036 10 Housewife Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname B Dewitt Myers Dorothy Mae Plunkert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. Linebarger Husband 13 Bon Oak Court, Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify Carrol1 Cremation 2/22/12 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road won Sus Eline Funeral Home Reisterstown, MD 21136 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** /Medical Approximate Interval a. Combined drug (Fentanyl and Oxycodone) Intoxication Between Onset and āxaminer Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and requires that the death certificate be executed Physician/Medical attending physician or use as the burial X UNPENDED AMENDED 23a, 27, 28a-f, per me, g926 4-23-12 sm Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 23d. Date of delivery Live birth past 12 months? 3 Ectopic pregnancy Fetal death Month Year Pregnant at time of death 5 1 Yes 2 No 9 Unknown Other (Specify) Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed Records, 1 Yes 2 No 3 Probably 4 V Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? Yes 2 ✔ No Hospital or Attending Physician: 1 Yes 25. Was case referred to medical of Vital Be 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA this Other Nursing Home 5 Residence 6 Other ٩ 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A 1 Natural the f Pending 1 Yes 2 🗶 No fd 2-19-12 2 ___ Accident unknown filled in by Investigation fd 3:00 pm 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) $13\ Bond\ Oak\ Ct$. (Specify) Residence 29a. Certifier 1 Reisterstown MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OCME February 20, 2012 30. Name and address of person who completed caus e of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD. State 31. Date filed (Month, Day, Year) 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Désedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year **Funeral** 1 DXM 2 □ F Months 217-96-3131 42 Director June 11,1969 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Dundalk 1 Yes 2 XNo Director Baltimore Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō ms 23a or 21222 6824 Youngstown Avenue USA Funeral Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Examiner 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 XMarried Maryland 21215-0036 ō 1 Yes 2 No Specify \$ Specify: White 3 Widowed 4 Divorced "natural" Completed Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore County 12 years Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil Lawson Theresa Parsons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 6824 Youngstown Avenue, Dundalk, MAryland Tammy Lawson other 1 permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 24, 2012 21. Signature of Funeral Service Lind Connelly Funeral Home Of Dundalk, P.A 7110 Sollers Point Road, Dundalk, MD. 21222 M0/17/0 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral ony arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions, if any learned limited to cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as CERTIFUL IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy Month Pregnant at time of death Day 5 Other (specify) 2 No the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 Probably 1 Yes 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has perform 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Other: 4 \sum Nursing Home Yes 2 □ No s after deaun. al Director: After this or in by the funeral di 2 ER/Outpatient 3 DOA မ 5 Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: ☐ Natural 5 Pending investigation Injury 28e. Place injury - At home, farm, street, factory, office building, etc. (Specify) 2 No 1 TYes 2 Accident Suicide 6 Could not be determined Route Number, Location (Street and Number or Rural completely filled in by 4 Homicide City or Town, State) HOME TOME

1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hospital of within 24 hours a To the Funeral D 29a. Certifier Medical (check only and manner stated. 29b. Signature and title of certifie License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) M. D Yama 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) Registrar's Signat State FEB 22 2012 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2 Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician/ BERNARD Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 220-24-7915 1 🛛 M 2 🗆 F Director 82 11/14/1929 MD Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Tes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 20 OVERMILL COURT 21117 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) SALESMAN FOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည MAURICE LAZOFF THERESA MYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUNE LAZOFF / WIFE 20 OVERMILL COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW 02/21/2012 REISTERSTOWN, MD 21. Signature of Puneral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician Medical

Examiner Examiner

that the death certificate be Box 68760

P.O.

Division of Vital Records. Hospital or Attending Physician: The law requires

has

24 hours

within 24

| Immediate Cause (Final disease or condition resulting in death) | a. Atherosclerohic O Due to (or as a consequence of): | adous | scula | On | nd Dea |
|--|--|-------|--------------------------|---------------|--------|
| Sequentially list conditions, if any leading to an activity cause. Enter Underlying Cause (Disease or injury | b | | | | |
| that initiated events resulting in death) Last | Due to (or as a consequence of): | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | | 23d. Date of de Month | livery Day | Year |
| Part II. Other significant condition | ons contributing to death but not resulting in the underlying cause given in Part I. | | co use contribute to | | _ |

Physician/Medical þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending work?
1 Yes 2 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of

State Registrar

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 28f per me,g924,02/22/2012dbb

Rea. No. 1 - State Registrar Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Day 2 ATHERINE 2012 Medical 4c. County of Death Facility Name (if not institution, **Examiner** City Town, or Location of Death JAINERSITY OF MARYLAND MEDICAL BACTIMORE 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) Director 1 □ M 2 🛛 F 213-26-1000 83 11/02/1928 Maryland Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director 1 Yes 2X No MD Harford <u>Joppa</u> 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? Examiner must be items 23a Funeral 914 Averill Road 21085 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural" 3 XWidowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Epsteins traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ George Meinschein Mary McKenna (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12603 Belair Road - Kingsville, Maryland Kimberly A. Miller-Barnum 21087 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 02/20/2012 Baltimore Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. <u> 11750 Belair Road - Kingsville, Maryland</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician/ PINAT disease or condition resulting in death) ORD Medical to (or as a consequence of) Examiner 02 CIDRN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) and I-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-MINER CERTIFICATION APPROVED BY MEDICAL EXA Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Dav Year detached the 9 Unknown 9 Unknown P.O. by been signed It should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate Yes 2 1 Ves 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: ပ္ 1 Npatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury
(Month, Day, Year)
(Peg 9 2012 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Jospital c.
4 hours after deac.
-ral Director: Afte Accident 5 Pending 1 Yes 2 No MOTOR Investigation 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, Cityor, Town, State) Tremble and Lohrs Roads Joppatowne 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check within 2 To the I Curtifying Nurse Prantitioner: To the best of my knowledge, deeth undured at the time date and place, and due to the cause(s) and main er as state 29b. Signature and title of certifier 29c. License number 29d: Date signed (Month, Day, Year)

Registrar

State

alow

22 South GREENE

sause of death (Item 23a) (Type, Print)

NICLIN

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 28a-1 per me, g924,02/15/2012 and Mental Hygiene 2 1 - For State Registrar 04979 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month onnie Martin 2012 807 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Bultimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Director 219-58-0468 1 □ M 2 🕇 F Usual Residence of Decede 59 21, 1952 Marvland 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Harford <u>Jarrettsville</u> ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 3732 Federal Hill Road 21084 items (USA 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) Para Educator Public Education is marked other 27 is marked other r traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be ment of Health and Ment John Martin Tipton Jr. Anna Mae Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Jack Martin / Son 2211 Cantley Drive, Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville Cem. Jarrettsville, MD Signature of Fun al Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. Bel Air, MD 21014 50 W. Broadway, 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph_sician/ Onset and Death to Ruptured aneurysm Subarachnoid Hamorrhage due disease or condition Medical resulting in death) Due to (or as a consequence of): CERTIFICATION APPROVED BY THE CEXAMINA Examiner 22.5hr Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events assisting in death) I ast Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Dav Year the 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No. within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Cay, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Work EAN GOILDON Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatule and title of certifier 29c. License number (Physician 101388

Registrar DHMH 17 Rev 06-2011

State

MO

FEBA

Khanjan Nagarsheth

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

S. G. reene St

32. Registrar's Signature

Baltimore

21201

MO

27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | 1 - For Amend Item Registrar | 25 State of M | 924,02/Pep Cer | of Pent of He tificate of De | ealth and N eath | | ene g. No. 2 A 1 2 | 01.980 |
|----------------------------|--|------------------|--|--|--|--|---------------------------------------|---|------------------------------|--|
| | Physicia | | 1. Decedent's Name (First, Middle, Kathleen | · / | McCull oug | h | | 2. Date of Death Month | Day 03 Year | 3. Time of Death |
| 1763 | Medi Examir | | 4a. Facility Name (if not institution, | | - total (1 out | 4b. City, Town, or L | ocation of Death | 02 | 4c. County of Dea | |
| | 7 | | University of N | Jamland N | ledical Center | | ore, M | D | 40. County of Bee | act i |
| | Funeral Director | | | | 68 Yrs. | If Under 1 Year | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Y Feb. 24 | ear) Co | rthplace (State or Foreign ountry) MD |
| | th with the Maryland ns 23a or 28a-f show must be notified at | ctor | 10a. State 10b. County | imore | 10c. City, Town or Loc | ation | | | | 10d. Inside City Limits |
| | ne Ma nr 28a notifi | Dire | 10e. Street and Number | | | | | | | 1 Yes 2 No |
| | with the Maryland s 23a or 28a-f sho ust be notified at | Funeral Director | 430 Essexw | ood Court | | 10f. Zip Code 212 | 21 | 10 | g. Citizen of What C USA | ountry? |
| 10 | hours after death natural", or items ical Examiner m | by Fun | 11. Marital Status 1 ☐ Never Married 2 ☒Marri | 12. Was Decedent I Armed Forces? 1 \(\subseteq \text{ Yes} \(2 \subsetext{ X} \) | lf. | /as Decedent of Hisp Yes, specify Cuban, | panic Origin? (Spe Mexican, Puerto | cify Yes or No- Rican, etc.) | 14. Race - Am Black, Whi | |
| 21215-0036 | urs afte ural", o | ted b | 3 Widowed 4 Divorced | If Yes, Give Year or Dates. | 1 | ☐ Yes 2 🛣 No | Specify: | | | hite |
| 15-(| 72 hou n "nati Tedica | Completed | 15. Decedent (Specify only highes | l's Education at grade completed) | (Give k | ent's Usual Occupati ind of work done dur | | ng 16 | 6b. Kind of Business | /Industry |
| | within /giene. her thau | Col | Elementary/Secondary (0-12) 12th | College (1-4 or 5 | | NOT use retired) eet MAna | ger | | State o | f Maryland |
| Maryland | permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. | To Be | 17. Father's Name (First, Middle, La Melv | ast) in C. Wanr | า | 1 | | e (First, Middle, Ma nerine F | den Surname) R. Milch | ling |
| đary | should n and M is is mar | | 19a. Informant's Name/Relationshi | | | Address (Street and | d Number or Rura | l Route Number, Ci | ity or Town, State, Zi | ip Code) |
| | I and 2 s f Health item 27 other tra | 1 8 | Donald McCu. 20a. Method of Disposition | Llough /hu | 20b. Place of Dispos | | | | timore I | MD 2122 1 |
| Baltimore, | permit. Page 1 Department of Important: If it any injury or o | | 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc | pecify) | | | tCemete | ry 2/7/ | 2012 Fr | eeland MD |
| Bal | permit Depar Impor any in | | 21. Sign, ture of Funeral Service Like | ia Bar | 2 | Name and Address Connelly | Funer | al Home | | |
| | | | 23a. Asset . Enter the disease, or o shock, or heart failure. List on Immediate Cause (Final | omplications that caused ily one cause on each line | the death. Do not enter | the mode of dying, | such as cardiac o | r respiratory arrest, | | Approximate Interval Between Onset and Death |
| | Medical | | disease or condition resulting in death) | a. Dumo | nam hu | morrhad | ye | | | Onset and Death |
| Jodan. | Examiner | ner | Sequentially list conditions, if any, leading to immediate | b. <u>dissem</u> Due to (or as a | inated ud | vavasaila | 1 was | ulation | | Iday |
| | ecuted and -transit | Examine | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | o Mondo | bactere | mia | // | TON EXAMINER | 2.5 months |
| 09. | ate be executed physician and the burial-transit | dical | recently addity and | | intestina | e bleed | 9 | MAPPROVED BY | EDICAL | 2 months |
| 687 | certifica nding p use as | n/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of | | | CERTIFICA | 104 | 23d. Date of de | livon |
| Box | Attending Physician: The law requires that the death certificate be executed redeath. redeath. ector. Attent this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit. | Physician/Me | in the past 12 months? 1 ☐ Yes 2 🗷 No 9 ☐ Unknown | 1 | | Ectopic pregnancy Other (specify) | | | Month | Day Year |
| , P.O. | s that igned b | | Part II. Other significant condition | | | • | | 23e. Did tobac | co use contribute to | the cause of death? |
| rds | requires been sig should b | eted | morbid obesite | | ic kidney | disease w | | | | robably 4 🔀 Unknown |
| Division of Vital Records, | The law cate has I page 2 s | Completed by | acute kidney i | njurg | | | | 24a. Was an autopsy performed | prior to death? | topsy findings available completion of cause of |
| ital | sician: certific irector | Be | 25. Was case referred to medical examiner? 1 X Yes 2 No | Hospital: | | Other | of Death (Check | | | |
| of V | ig Physer this | te: To | 27. Manner of Death | 28a. Date of injur | | 28c. Injury at | | ne 5 Residence 8d. Describe how i | e 6 Other (Spec | ify) |
| ion | tendin Jeath Ior Aff the fur | Certificate: | 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could no | ition | Year) injury | M 1 ☐ Yes | 3 2 No | | | |
| Divis | tal or Atrice al Direct | I Cert | 4 Homicide determin | | ry - At home, farm, stree (Specify) | t, factory, office | 2 | 8f. Location (Stree City or Town, S. | t and Number or Rui tate) | ral Route Number, |
| | To the Hospital or Attending Physician: The law within 24 brous are death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2. | Medical | Check 2 Medical Exa | Physician: To the best of raminer: On the basis of ex lurse Practitioner: To the | amination and/or investig | ation in my opinion of | heath occurred at t | he time date and n | lace and due to the | auce(c) and manner stated |
| _ | within To the com | | 29b. Signature and title of certifier | 2 | | 29c. License nu | | | Date signed (Month | |
| J | | | 74/1 | 2 | | P273 | 31 | O: | 2/03/2 | 0/2 |
| | | | 30. Name and address of person wh | no completed cause of de | | | | 010-7 | , | |
| | State | ٠ ا | 31. Date filed (Month, Day, Year) FEB 1 6 20 | 32. Registrar | ivelne St- | ba home | e, MD | 4101 | | |
| | Registra | r | LED T 0 50 | 14 Senga | B. Bark | | | | | |

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| | | | For | - | epartment of Health and | Mental Hygier | |
|---------------------------------|--|------------------|--|---|--|--|--|
| | | | State Registrar | | Certificate of Death | Reg. I | |
| | Physicia | ın/ | 1. Decedent's Name (First, Middle, La | * | | 2. Date of Death | Day Year 3. Time of Death |
| | Medic | | Robert P. | martin | | February | |
| | Examir | er | 4a. Facility Name (if not institution, giv | | 4b. City, Town, or Location of Deat Bourtimere | h | 4c. County of Death |
| | | | | any land medical Cent | | | 9. Birthplace (State or Foreign |
| | Funeral Director | | 411 15 01710 | lat | Months Days Hours Min. | (Month, Day, Year | r) Country) |
| | | | Usual Residence of Decedent | M 2 L F 6/ Yr | S. | 1-31-195 | 1 MD |
| | and shov | 힏 | 10a. State 10b. County | 10c. City, Town o | | | 10d. Inside City Limits |
| | Maryl 28a-f etifie | rec | MD N | A Balt | imore | | 1 X Yes 2 No |
| | a or 2 | Ō | 10e. Street and Number | 4 1 | 10f. Zip Code | 10g. | Citizen of What Country? |
| | s 23 | Funeral Director | 1243 GIENWO | od Ave. | 21239 | | USA |
| | item item ner n | Fu | 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No | Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer | pecify Yes or No- to Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| 36 | after I", or xami | d by | 1 Never Married 2 Married 3 Widowed 4 Divorced | If Yes, Give | 1 ☐ Yes 2 No Specity: | | Specify: Black |
| 8 | ours atura cal E | etec | 15. Decedent's | Year or Dates. | ecedent's Usual Occupation | 16h | . Kind of Business/Industry |
| 7. | 72 h In "ni Medii | Completed | (Specify only highest g | rade completed) (C | Sive kind of work done during most of wo ie. DO NOT use retired) | rking | . Kind of Business/industry |
| 212 | within jiene. er the | | Elementary/Secondary (0-12) | College (1-4 or 5+) "" | Truck Driver | B | Ohaggars Irucking C |
| ٦ | filed all Hyg | Be | 17. Father's Name (First, Middle, Last) | 4 | | me (First, Middle, Maide | |
| <u>la</u> | d be Menta arkec | ၀ | Luther Mar | tin | Nani | rie Walk | ter |
| Maryland 21215-0036 | shoul and I is mi | | 19a. Informant's Name/Relationship (| | Mailing Address (Street and Number or Re | | |
| ≥ ′ | nd 2 lealth m 27 | | Teresa Martin- | | 3 Avondale Rd. | Dimdall | |
| ore | t of H | | 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ | | hisposition (Name of crematory or other place) | /. ! | Location - City or Town, State |
| 럝 | t. Pag tmen rtant: njury | | 4 ☐ Donation 5 ☐ Other (Spec | | ion Cemetery do | 25/2012 La | nsdown, MD |
| Baltimore, | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Funeral Service Licer |) / - / / / / / / / / / / / / / / / / / | Baltimore, MD 2 | arch FlH-Eas | + 1101 E. North Ave |
| i | | | 23a. Part 1 Enter the disease, or cor | pplications that caused the death. Do not | | or respiratory arrest. | Approximate |
| ١, | N | | shock or heart failure. List only | one cause on each line. | | | Interval Between Onset and Death |
| | Physician/ Medical | | Immediate Cause (Final disease or condition resulting in death) | a. Pulmonar Due to (or as a consequence of): | y tmbolism | | |
| ~~ | Examiner | | | Ronal M | Maliananair | | |
| Е | | ner | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a consequence of): | 3 | | |
| | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | G | | | |
| | exec an an irial-ti | Ě | resulting in death) Last | Due to (or as a consequence of): | | | |
| 760 | cate be executed physician and sthe burial-transit | edical | • | d | | | |
| 87 | rtifica ing p | ₩ | IF FEMALE: | 00. 14 | | | |
| Box 68 | th ce ttend or us | ian | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | 23d. Date of delivery Month Day Year |
| ĕ | e dea the a | Physician/M | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | g Unknown | 3 🗆 Other (specify) | | |
| Ö. | requires that the death certific been signed by the attending is should be detached for use as | | Part II. Other significant conditions | contributing to death but not resulting in | the underlying cause given in Part I. | 23e. Did tobacc | co use contribute to the cause of death? |
| S, | ires t sign Id be | d by | | | | 1 ☐ Yes | 2 No 3 Probably 4 Unknown |
| ord | / requ | Completed | | | | 24a. Was an | 24b. Were autopsy findings available |
| ec | re law e has age 2 | E G | | | | autopsy performed | |
| E E | sician: The certificate rector, pag | Be C | 25. Was case referred to medical | | 26. Place of Death (Che | | No 1 Yes 2 No |
| Ζit; | ysician: The la is certificate ha director, page | To B | examiner? 1 ☐ Yes 2 No | Hospital: | eatient 3 DOA Other: 4 Nursing | Home 5 Residence | 6 Other (Specify) |
| of | ding Phys th. After this funeral di | | 27. Manner of Death 1 Natural 5 □ Pending | 28a. Date of injury (Month, Day, Year) 28b. Tin | 19 of 28c. Injury at | 28d. Describe how in | |
| on | Attendin er death. ector: Aff by the fu | fica | 2 Accident Investigation | on loo | M 1 Yes 2 No | | |
| Division of Vital Records, P.O. | ospital or Attending Physician: The law requires that the death certificate be executed in hours after death. Incurs after death. uneral Director: After this certificate has been signed by the attending physician and siy filled in by the funeral director, page 2 should be detached for use as the burial-transi | Certificate: | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined | | , street, factory, office | 28f. Location (Street City or Town, Sta | and Number or Rural Route Number, ate) |
| Ö | lospital or t hours afte uneral Din ely filled in | dical C | | | -Marian disk disk disk disk disk disk disk disk | | a) and manufactured obstacl |
| | os h h | Ιĕ | 29a. Certifier 1 Certifying Ph | ysician: To the best of my knowledge, de | earn occurred at the time, date and place | and due to the cause(s | s) and manner as stated. ace, and due to the cause(s) and manner stat |

ner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1487979720

29d. Date signed (Month, Day, Year) February 16, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St. Baltimore; MD 21201 Toric Grant, mp 22 S. Greene

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia R. McGainey Medical 19 February 2012 3:15 p^M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1805 Stevens Drive Edgewood Harford Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 213-28-0568 Hours (Month, Day, Year, **Director** 1 🗆 M 2 🕱 F 82 Yrs June 2,1929 Maryland Usual Residence of Decedent 28a-f show with the Maryland 10a. State notified at 10b County 10c. City, Town or Location Director 10d. Inside City Limits Md. Harford Edgewood 1 🗌 Yes 2 🔀 No ō 10e Street and Number 10f. Zip Code ural", or items 23a o 10g. Citizen of What Country? by Funeral 1805 Stevens Drive 21040 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner musonee. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify. Completed 3 XWidowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 years Meadow Gold Ice Cream Factory Line Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ George Clavell Loretta Clavell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia R. Bentley Daughter 327 Outlaw Trail, Maysville, WVA 26833 20a. Method of Disposition 20b. Place of Disposition (Name of February 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Holly Hill Cemetery 23, 2012 Middle River, Maryland 21. Signature of Funeral Service Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ BSTRUCTVE HERONI C PULM ONAR nset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ρģ Day signed by the at I be detached for Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Colon Cancer Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 hours after death. Ineral Director: After this certificate h 1 Yes the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed cause of death (Item 23a) (Type, Print) #102 Busness Date filed (Month, Day, State FEB 2 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

for State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Mcbride Month nette 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death (arroll ltospita Westminster (arro 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Sept. 21 Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F Hours 182-28-3688 Year) Count Director Sept. Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Carroll Westminster 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 45 Washington Road 21157 <u>United States</u> 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married P þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", 3 X Widowed 4 ☐ Divorced Completed white er than "natur , the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12th Housewife own Home is marked other Be permit. Page 1 and 2 should be filed a Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clyde Louderback Phyllis Gough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth Azat 3219 Hooper Road New Windsor, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Epiphany Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Feb. 18, 2012 Odenton. Sign de of Funeral Service Lic 22. Name and Address of Facility & Crematory, Burrier-Queen Funeral Home 1212 W. Old Liberty Rooad dons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Winfield, P /t 1. Enter the disease, or complication, or heart failure. List only one Approximate Interval Between ediate Cause (Final Onset and Death Physician/ di ease or condition Medical esulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last signed by the attending physician and d be detached for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗆 Yes 2 No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death ë 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Certificat 1 🗌 Yes Accident 2 🗌 No Investigation 24 hours after deatl Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original death account. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar DHMH 17 Rev 7/2009 32. Registrar's Signatu

2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February 2012 GRACE NORTON 1:45 ΔM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 8. Date of Birth 1 🗆 M 2 🛛 F Days Min. Hours AUG. 5, 1918 Director NEW YORK 109-09-0769 93 Usual Residence of Decedent show 10a. State 10b. County Ħ 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland Frederick 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code pe 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a Funeral ed other than "natural", or items 23a event, the Medical Examiner must b 7193 C Cypress Court 21701 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, ģ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Liebacker Mary O'Brien other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Doyle (Daughter) 113 Joni Dr., West Sayville, NY 11796 20b. Place of Disposition (Name of Longete Legislate) or other place)
National Cemetery 20a. Method of Disposition Department of H Important: If ite any injury or ot once. Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 2/23/2012 Pinelawn, NY 4 Donation 5 Other (Specify) 21. Signature of Faneral Service Liminse . Name and Address of Facilit Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Examiner ~ a Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying burial-transif Cause (Disease or linjury that initiated events and Due to (or as a consequence of resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy ō in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year the 9 Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has certificate performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita Other: 201 No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours after death.

he Funeral Director: After this pleted filled in by the funeral di this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural $5 \square$ Pending injury 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted f (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number cause of death (Item 23a) (Type, Print) dress of person GAIFE TOUL HOUSE MO 800 31. Date filed (Month, Day, Year) FEB 2 2 2012 is Signatur 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 20, Eddie Roger Neal 2012 8:00 PM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4 E. 30th Street, Apt. Baltimore Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 491-48-2556 **Director** 1 **X** M 2 □ F 67 JAN 5, 1945 California Usual Residence of Decede 28a-f show 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD N/A 1 X Yes 2 No Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4 E. 30th Street, Apt. 2 21218 USA items 2 . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
tant! filem 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever In O.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates.Vietnam 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Case Worker Consumer Protection Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unk. Nea1 Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tuan A. Venetta, friend/beneficiary 3616 Yolando Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/21/12 Baltimore, MD George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition oronany Medical resulting in death) Due to (or as a nsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and nding physician and use as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Dav Year signed by the all ld be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed Chronic Kilney dispare 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 1 🗆 Yes 1 Yes 2 No funeral director, 25. Was case referred Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 00063347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011 ...

Keman

31. Date filed (Month, Day, Year)

FEB 2 2 2012

3100

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | - | For State Registrar | State of Ma | aryland / | Department of Certificate of | | 1ental Hy | gien Reg. 1 | 2012 | 04986 |
|--|-----------|--|--|----------------------------|---|---|---------------------------------|---------------------|---|--|
| Physician | , | 1. Decedent's Name (First, Middle, La | st) | | | | 2. Date of De | ath | | 3. Time of Death |
| Physician Medica | al I | BERNARD | | | POPICK | | Month FEBRU | ARY | 19 2012 | 12:30A M |
| Examine | r | 4a. Facility Name (if not institution, give | NUING CARE | | | or Location of Death | | 4 | 4c. County of Death | |
| Funeral | | FAIRHAVEN, RETIR | | JNITY (In yrs. last bir | SYKESV thday) If Under 1 Year | | 8. Date of Bir | th. | CARROLL | |
| Director | | | X) M 2 □ F | 94 | Months Dave | | 09/15/ | , 1 ⁷ 97 | 7 Cour | place (State or Foreign htry) NJ |
| and show | - 1 | 10a. State 10b. County | | 10c. City, Tow | n or Location | | | | | 10d. Inside City Limits |
| Maryl 28a-f | Director | MD CARRO | LL | SYKE | SVILLE | | | | | 1 ☐ Yes 2 💢 No |
| h the | <u>a</u> | Oe, Street and Number | | | 10f. Zip Code | | | 10g. (| Citizen of What Cou | ntry? |
| ms 23 | runeral | 7200 3RD AVENUE | Leave a second | | 21784 | | | 1 | USA | |
| or ite | 2 | Marital Status Never Married 2 Married | 12. Was Decedent Ev Armed Forces? 1 \(\sum \) Yes 2 \(\overline{\text{X}} \) \(\overline{\text{N}} \) | | 13. Was Decedent of I If Yes, specify Cub | Hispanic Origin? (Spe- an, Mexican, Puerto f | cify Yes or No- Rican, etc.) | | 14. Race - Americ Black, White, | |
| O36 | | 3 Nidowed 4 Divorced | If Yes, Give Year or Dates. | 40 | 1 ☐ Yes 2 🗓 No | Specify: | | | Specify: WHI | тъ |
| Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o mortant: If item 27 is marked other than "natural", o more. To Be Completed by | Completed | 15. Decedent's E (Specify only highest gr | | 16a | . Decedent's Usual Occup (Give kind of work done | pation | 20 | 16b. | Kind of Business In | |
| thin 7; than than be M. | ξļ | Elementary/Seconday (0-12) | College (1-4 or 5- | +) | life. DO NOT use retired. DIRECTOR, B DISABILITY | UREAU OF | | U. | S. GOVERI | NMENT - |
| id 2 | | 7. Father's Name (First, Middle, Last) | 4 | | DISABILITY | | | | | RITY ADMIN. |
| land be filed vental Hygerked other ic event. | | JACOB | | POP | TCK | 18. Mother's Name PEARL | (FIFST, IVIIDDIE, | iviaidei | STE | TN |
| Aarylane should be flie n and Mental I 7 is marked o raumatic eve | Ì | 19a. Informant's Name/Relationship (7 | ype, Print) | | . Mailing Address (Street | | Route Numbe | r. City o | | |
| nd 2 s ealth m 27 iner tre | | BARBARA P. ROSIN | NG / DAUGHT | | 9508 BROOK | | | | | , |
| Ore Titel a | ľ | 0a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X | Removal from State | | f Disposition (Name of ry, crematory or other place | D | ate | | Location - City or To | own, State |
| t. Pag tmen tant: | | 4 Donation 5 Other (Special | 5y) | M | Γ LEBANON | 02/21 | | | SELIN, N | |
| Baltimore, Maryland 21215-0036 permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signatur of Funeral Service Licens | 1 Helen | | | ess of Facility SOL | | | | |
| | + | 23a. Part 1. Enter the disease, or com | plications that caused t | the death. Do r | | | | | CESVILLE, | Approximate |
| Physician/ | | shock, or heart failure. List only o Immediate Cause (Final disease or condition | ne cause on each line. | * | | | | | 14 | Interval Between Onset and Death |
| Medical | | resulting in death) | a. Due to (or as a | consequence of | of): | | | | - 0 | ays |
| Examiner | | Sequentially list conditions, | b. — | | | | | | | |
| vecuted nand sl-transit | | if any, leading to immediate cause. Enter Underlying | Due to (or as a | consequence o | of): | | | | | |
| execut n and ial-trar | | that initiated events resulting in death) Last | Due to (or as a | consequence o | of): | | | | | |
| 760 cate be exphysician s the burial edical | | | d | | | | | | | |
| 876 tificat ing ph | + | FEMALE; | | | | | | | | |
| or use | 2 | 3b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of 1 Live Birth 2 | f pregnancy Great death | 3 Ectopic pregnance | су | | - | 23d. Date of delive | * |
| O. Box 68' t the death certific by the attending stached for use as Physician/M | | 1 Yes 2 No 9 Unknown | 4 ☐ Pregnant at t g ☐ Unknown | time of death | 5 ☐ Other (specify) _ | | | | Month | Day Year |
| P.O. s that the gned by se detact | | art II. Other significant conditions co | entributing to death but | not resulting i | n the underlying cause given | ven in Part I. | 23e. Did to | bacco | use contribute to th | e cause of death? |
| uires i uires i uid be | - | type II dia | betes. | .,. | | | 1 □ Y | es 2 | No 3 ☐ Prob | oably 4 🗆 Unknown |
| w req | | concestive | heart fo | ailun | | | 24a. Was a | | 24b. Were autop | osy findings available npletion of cause of |
| Records, The law requirer are has been six page 2 should the Completed | | dysphacia | | | | | autop perfor 1 Yes | sy ned? | prior to con death? Io 1 \sum Yes | |
| cian: ertific ector, | | 5. Was case referred o medical examiner? | U | | | ace of Death (Check of | _ | 1 | 101 103 | 2 110 |
| Physical directions: To: | | 1 ☐ Yes 2 No 7. Manner of Death | | | tpatient 3 DOA Othe | 4 Nursing Hom | ne 5 🗆 Reside | ence (| 6 ☐ Other (Specify) | |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Whe Funeral Director, Hether this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exam | | Natural 5 Pending Accident Investigation | 28a. Date of injury (Month, Day, | | jury work | | 3d. Describe ho | ow inju | ry occurred | |
| isic Atter ar dea ector by the | | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury | / - At home, far | m, street, factory, office | | 8f. Location (St | reet an | nd Number or Rural | Route Number. |
| Div Ital or Ital or al Dir led in | | | building, etc. | | | | City or Town | | • | |
| De Hospita in 24 hours ne Funeral pleted filled | 2 | (Check Z — Medical Exami | i er: Un the basis of exa | mination and/or | leath occured at the time, investigation, in my opinio | on death occurred at ti | a timo data an | d place | and due to the equ | co(c) and manner stated |
| ithin 2 the orthe orthe orthe orthe | _ | only one) 3 Certifying Nurs 3b. Signature and title of certifier | e Practioner: To the be | est of my knowle | edge, death occurred at the | e time, date and place, | and due to the | cause(| s) and manner as sta | ited. |
| F 3 F 5 | | DI 1000 | illi | | 336 | | | | ate signed (Month, E | 2012 |
| 0 | 3 |). Name and address of person who co | ompleted cause of dea | th (Item 23a) (T | - 67 | 10 11 | | 20 | nory . I | 30,0 |
| 7 | | William Tan i | n) 16 | 45 Lil | sexty Rd | E Iders | burg 1 | 10 | 21784 | • |
| State Registrar | 3 | Date filed (Month, Day, Year) FEB 2 2 2012 | 32: Registrar's | s Signature | . 4.1 | | - | | | |
| DHMH 17 Rev 7/2009 | | · FO E W LUIL | (AND) | p. g | N/CEP | | | | | |
| bu | | | | ODICI | 1014 | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr g924 2-22-12 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 ebruar Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore Examiner 4b. City, Town, or Location of Death Northwest Hospital Randallstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 XM 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Min. Country 216-78-4639 Yrs **Director** 3-17-1963 Usual Residence of Decedent 28a-f show 10b. County 10a. State filed within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD n/a Baltimore 1X Yes 2 ☐ No 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21229 USA 4235 Old Frederick Road items 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or by 1 X Never Married 2 Married Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify SpecifyAfrican-American 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than " Page 1 and 2 should be filed within ment of Health and Mental Hygiene. cant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Machine Operator Office Depot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Milton Parker Sr., Carolyn Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Jones Parker/Mother 4235 Old Frederick Rd., Baltimore, MD 21229 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Tother (Specify) 2-28-2012 Owings Mills, MD Garrison Forest Veterans Signature of Funeral Service Licers 22. Name and Address of Facility Wile Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that chesed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Ira tore Medical Due to (of as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter oncerning Cause (Disease or linjury Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ó Month Day Year 1 Yes 2 L 9 Unknown be detached signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2 🗌 No Yes 2 1 🗌 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital: Other: 2 🗆 No ျာ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director, After 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary A. McCumber Northwest Hospital Randallstown, MD, 21133

☐ DHMH 17 Rev 7/2009

State Registrar 32. Registrate Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 14705 Triadelphia Mill Road Dayton Howard . Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 052-28-8126 **Director** 1 □ M 2 🛛 F 76 Mar 2, 1935 New York 28a-f shov Examiner must be notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Tes 2 No MD Howard Dayton ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 14705 Triadelphia Mill Road 21036 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after "natural", 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Nurses Aide Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Coleman Anna Louise Force 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Pack, Sr. 14705 Triadelphia Mill Rd. Dayton, MD 21036 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Final Journey Crematory 02/21/12 4 Donation 5 Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licensee Solve the Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ inset and Death disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Day to (or as a consequence of) it any leading to immedicause. Enter Underlying Examin Cause (Disease or injury that initiated events physician and as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director; After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 use as ate has been signed by the attending page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Year Pregnant at time of death Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 🗌 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene per me,g924,02/16/2012dhb Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year CAROLYN 26 Oi 2017 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** N/A 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 218-52-0890 Yrs. MD Apr 27, 1949 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD **Baltimore** 1 Xes 2 No Randallstown 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 9019 Samoset Road 21133 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∏ Yes 2 TXNo Specify 3 Widowed 4 Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Laborer **General Motors** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Melvin Price Helen P. Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Williams 9019 Samoset Road. Randalistown, MD 21133 One Mathed of Discovition

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show

Examiner must be notified at

Director

Funeral

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Completed

Be

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death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nah...." any liquy or other traumatic e.....

28cot Tax to ME Division of Vital Records, P.O. Box 68760,

or Attending Physician:

filled in by the funeral director,

within 24 hours after death.

To the Funeral Director: After this

| | " |
|---|-------------|
| Examiner | S if C C th |
| ertification: To Be Completed by Physician/Medical Examiner | IF 2: |
| by Phys | P |
| completed | - |
| Be C | 2 |
| ertification: Te | 27 |

| 1 X Burial 2 Cremation | | cemetery, crematory | (Name of or other place) | Date | 20c. Location - City o | r Town, State |
|---|--|---|--|--|---|---|
| 4 ☐ Donation 5 ☐ Other (Sp | ecify) | Cedar Hill Co | emetery & | Feb 01, 2012 | Brookly | n Park, Md. |
| 21. Signature Funeral Service Li | ensee | 22. Nam | e and Address of Fac | , | 12.2 | |
| Xlory | M. Cotto | | Estep Brothers 1300 Futaw Pla | Funeral Service, ce Baltimore, Md | P. A. 21217 | |
| 23a. Part 1. Enter the disease, or of shock, or heart failure. List of | omplications that caused the | death. Do not enter the | mode of dying, such a | as cardiac or respiratory | arrest, | Approximate Interval Between |
| Immediate Cause (Final disease or condition | - CARDIO | PULMULARY | ACCEST | | | Onset and Death |
| resulting in death) | Due to (or as a co | nsequence of): | | | | |
| Sequentially list conditions if any, leading to immediate cause. Enter Underlying | b. Due to (or as a co | nsequence of): | RPHAGE | | 1-1 | 1 week |
| Cause (Disease or injury that initiated events | c | | | PICATION APPROVED BY M | EVAMINER | |
| resulting in death) Last | Due to (or as a co | nsequence of): | _ | C AND ENTIT | EDICAL | |
| \ | d | | | CATION APPROVED | | |
| IF FEMALE: | | | CEKI | [No.] | | |
| 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | 23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown | Fetal death 3 Ector | oic pregnancy (specify) | | 23d. Date of de Month | elivery Day Year |
| Part II. Other significant condition | s contributing to death but no | at resulting in the underly | ing cause given in Pa | rt I 23a Did | tobacco use contribute | to the cause of death? |
| | 3 | | ing cauco given in ra | 1 🗆 | | robably 4 Unknow |
| | | | | | | |
| | | | | 24a. Was auto perfo | psy prior to ormed? prior to death? | utopsy findings available completion of cause of s 2 \sum No |
| 25. Was case referred to medical examiner? | | | 26. Plac | e of Death (Check only of | one) | |
| 1 X Yes ≥ 1√10 | Hospital: 1 Inpatient | 2 ER/Outpatient 3 E | IDOA Other: 4 🗆 N | ursing Home 5 🗆 Resi | dence 6 Other (Spe | cify) |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga | 28a. Date of Injury (Month, Day Year | 28b. Time of Injury | 28c. Injury at Work? 1 Yes 2 | | how injury occurred | · · · · · · · · · · · · · · · · · · · |
| 3 Suicide 6 Could no determin | | At home, farm, street, fac pecify) | tory, office | 28f. Location City or Tox | (Street and Number or F vn, State) | Rural Route Number, |
| 29a. Certifier 1 Certifying (check only one) 2 Medical E | Physician: To the best of my xaminer: On the basis of examiner stated. | knowledge, death occur mination and/or investiga | red at the time, date a tion, in my opinion, de | and place, and due to the eath occurred at the time | cause(s) and manner a , date and place, and du | s stated. ue to the cause(s) |
| 29b. Signature and title of certifier | | | 29c. License number | | 29d. Date signed (Mont | h, Day, Year) |
| 1 | HE C | | REC-10 | 0 | 01/71 | 12013 |

4940 Eastern Avenue, Baltimore, MD, 21224

Registrar

State

31. Date filed (Month, Day, Year)

FEB 1 6 2012

Type and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

| Gregory | Dean | Poorman |
|---------|------|---------|
| 5 , | | |

State of Maryland / Department of Health and Mental Hygiene

| 2 | 0 | Q | 2 | 0 | L | 9 | 9 | 1 |
|-------------|---|----------|-----|---|-----|---|---|---|
| \subseteq | U | 1 | b-m | | - 7 | 1 | 1 | - |

| | | | 1- For State Registrar | | Ce | rtificate of | Death | | Re | g. No. | - 04777 |
|---|--|----------------|--|--|--|------------------------|---|-------------------------------------|---|--|--|
| Phyledical E | ysici: xami | an/ | 1. Decedent's Name (First, Middl Gregory Dean P | oorman | | | | | 2. Date of Death Month February 1 | Day Year 7, 2012 | 3. Time of Death 0830 hrs |
| , | | | 4a. Facility Name (if not institutio 711 Bald Eagle Lane | n, give street and nur | nber) | 4 | b. City, Town, or L Lusby | ocation of Deat | h | 4c. County of Dea | ath |
| | eral ctor | | 5. Social Security Number 348-44-5362 384-44-5362 | 6. Sex | 7. Age (In yrs. 61 | last birthday) Yrs. | Months Days | If Under 24Hr Hours Mir | n. | Fore | Birthplace (State or eign |
| ри | 28a-f show any l at once. | or | Usual Residence of Decedent 10a. State 10b. County Maryland Calve | ert | | , Town or Location | on | | | | 10d. Inside City Limits 1 Yes 2 No |
| the Maryla | items 23a or 28a-f sho ast be notified at once. | | 10e. Street and Number 711 Bald Eagle | Lane | • | | 10f. Zip Code 20657 | | 10 | g. Citizen of What Co | ountry? |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. | 17, or | by Funeral | 3 Widowed 4 Div | arried Armed Fo. 1 X Yes orced If Yes, Give Year or Dates: | 2 No | If Ye | Decedent of Hisp s, specify Cuban, Yes 2 No | Mexican, Puerto | | White, etc. | erican Indian, Black, Thite |
| 1 36 hin 72 hours e. | it: If item 27 is marked other than "natural other traumatic event, the Medical Examin | Completed t | 15. Decedent's Education (Spec Elementary/Secondary (0-12) 12 | College (1- | | during mo | s Usual Occupation st of working life. I Chnician | | | 16b. Kind of Busines Computer | s/Industry Company |
| 21215-0036 uld be filed within 7 Mental Hygiene. | ked other | Be Com | 17. Father's Name (First, Middle, Albert Dean Po | Last) | | 7. | | B.Mother's Name Grace Sl | e (First, Middle, M narp | - | |
| MD 21; d 2 should b lth and Men | umatic eve | 2 | 19a. Informant's Name/Relationsl Douglas Poorma | | er) | 4.4 | | | | ber, City or Town, Sta 1 , $$ IL $$ 6244 | |
| Baltimore, bermit. Pages 1 and Department of Heal | Important: If item 27 is marked oth injury or other traumatic event, the | | 20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Sp | peity:) | m State | crematory or oth | n Cemeter | ry 2/. | Date 25/2012 | 20c. Location - City of | 11, IL |
| Balt permit. Departs | Importingury | | 21. Ignature of Funeral Service | Mun | | 22, Na Me 55 | ame and Address of tropolita 17 Vine S | of Facility an Fune: St., Ale | ral Servi exandria | ice , VA 22310 | |
| Physic /Med Exam | lical | | 23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease | on each line. a. Hypertensiv | e Atherosc | lerotic Cardio | | | or respiratory arre | st, shock, or heart | Approximate Interval Between Onset and Death |
| | | ы | or condition resulting in death) Sequentially list conditions, if any, leading to immediate | Due to (or as a b | | | | | | | |
| , V = | sit | Examiner | (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a | consequence o | of): | | | | | |
| be execute | physician and the burial - transit | /Medical E | UNPENDED | d | 5perFH. | ,G925,3/ | 16/2012, | WS. | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | attending phys for use as the b | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 Unk | 23c. If yes, o | utcome of preg rth int at time of de | nancy 2 Feta | al death 3 er (Specify) | | ancy | 23d. Date of delive Month | ery Day Year |
| P.O. Be | signed by the be detached for | 百 | Part II. Other significant condition chronic obstructive pu | ions contributing to | death but not r | esulting in the ur | nderlying cause giv | ven in Part I. | | | o the cause of death? |
| Division of Vital Records, talor Attending Physician: The law require is after death. | has been signed a should be | Completed | | | | | | | 24a. Was a autops | y prior to ned? death? | |
| . | certificate ector, page | | 25. Was case referred to medical | | | | 26 Place o | of Death (Check | 1 Yes 2 | No 1 🗸 | Yes 2 No |
| Vita ysicia | this cer directo | o Be | examiner? 1 ✓ Yes 2 No | Il territali am | patient 2 | ER/Outpatient | | 44 | | Residence 6 🗹 Oth | er: Scene |
| ion of tending Ph | tor: After this certificate the funeral director, page | ation: T | 27. Manner of Death 1 Natural 5 Pend | | of Injury Day,Year) | 28b. Time of In | | at Work? | 28d. Describe ho | ow injury occurred | |
| Divis pital or At ours after d | filled in by | Certification: | 3 Suicide 6 Could deter | | of Injury - At h | ome, farm, street | , factory, office bui | ilding, etc. | 28f. Location (Story Town, Stary Stary) | | Rural Route Number, City |
| To the Hos within 24 h | To the Funeral Direct completely filled in by | edical | one) 2 Medical Exar | nysician: To the best miner:On the basis of and manner sta | examination a | | on, in my opinion, o | death occurred | | nd place, and due to | the cause(s) |
| | | × | 29b. Signature and title of certifie | on flow | 9 | | 29c. License O.C.M | | | February 18, 20 | |
| / | Q | | 30. Name and address of person Melissa Brassell, MD | who completed cause Assistant Med | | | Baltimore Str | eet, Baltimo | ore, MD 21223 | 3 | |
| | | ate | 31. Date 114 (12/19/19/19/19) | | gistratis Signat | • | | | | | ,-,- |
| R | egist | | | 1001- | 1 (1 | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death QQ . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Day Phoebus 14:03 M Betty Μ. 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital Balti more Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Min. Hours Jan. 6. Country) 83 Director 213-26-9188 Maryland Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Catonsville 1 Yes 2 XNo 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21228 United States 1-H Stayman Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married "natural", or 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Social Security Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other tha Budget Analyst Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Charles McKinley Meryl Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 3668 W. Watersville Rd., Mt. Airy, Maryland 21771 Patti Sengebusch/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Important: If injury or Lakeview Mem'l Park |02/20/2012 |Sykesville, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility MacNabb Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications 301 Frederick Rd., Catonsville, Maryland 21228 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Servere Physician/ Septic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter University Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day be detached by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform After this certificate 1 Yes 2 No Yes O No Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' é 1 Yes PNo Other: + ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Division of the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 Yes 2 No Accident Suicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, oearn excurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D 24064 16/2012

State Registrar

101

Baltimore, MD. 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04992 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Evelyn Picker FEBRUARY 238PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNEG HOSPITAL BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Hours Country)
Marvland Director 215-30-7514 Usual Residence of Decedent show f permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Arbutus 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1261 June Road 21227 United States of America 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Management Financial industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James J. Brzeczko Bertha Majewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Picker -Son 1261 June Road, Arbutus, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadow ridge Cemetery 2/20/2012 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death

DAYS Priysician/ PSEUDOMONAS PNEUMONIA disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): SPERGILLOSIS UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit STAGE 3 LUNG CANCER UNKNOWN Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE PULMONARY Completed 1 Yes 2 No 3 Probably 4 Unknown ASPIRATION FECULENT MATERIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate performed' Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ပ Other: 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AS2438528 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARUPUDI 900 SINDHUJA CATON AVE, BALTIMORE, MD 31. Date filed (Month, Day, Year) State 2. Registrar's Sign

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month CHARLES J. PORTER 2:15 P M 02 19 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Ruxton Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/05/1960 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 219-60-7105 51 **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 TyYes 2 □ No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3916 Pinkney Road 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 ☑ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Its Ma Elementary/Secondary (0-12) College (1-4or 5+) housekeeping hote1 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles L. Porter Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Susan Meckel / Sister 9415 Horn Ave.; Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory. Inc. 02/21/2012 Catonsville.MD

22. Name and Address of Facility
The Johnson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M-ec217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Apr. Immediate Cause (Final Approximate Interval Between Onset and Death neumonia **Physician** resulting in death) /Medical or as a consequence of): Embolism Harombosis Examiner ulmonan So ventially list and it on if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician a for use as the burial-Due to (or as a consequence of): Box 68760 Down Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 ☐ Yes 2 = No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA of 27. May er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the within 2 To the I 29c. License number

D 52749 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02-19-12 JAYANT HIRPARA MO. person who completed cause of death (Item 23a) (Type, Print) 30. Name and address TOWSON Drive 21204 32 Registrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year OPM JEAN TLORIA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE MAI 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Ye 1 M 2 1 Months Hours Min 55 Yrs 213-68-908 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 I es 2 No CIT BATIMORE MD TIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 10 Specify: If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'am injury or other traumatic event, the Meone. CHAR ITABLE life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ORGANIZATIONS FLEMARKETER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ KEACAN MITCHARD ERALD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mD CORLETT - DAICHTER DUNWICH ALTIMERE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 2-23-12 4 Donation 5 Other (Specify) ATLANTIC CREMOTIES GLEN BURNIE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKARDA FUNERAL HOME BALTIMURG HUDSUN ST. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ~Physician/ duance me co love disease or condition resulting in death) **Medical** Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Citysque Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 pronths?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year Pregnant at time of death 9 Unknown been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending iniury 2 🗌 No Investigation Accident within 24 hours after death To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12006136 mD 22 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Wolfe St

28

MD

600 N.

-Montes

32. Registrar's S

12142

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | for State | State of Marylan | | | | d Mental Hy | giene | |
|--------------------------------|---|------------------|---|---|---------------------|---|---------------------------|---|--|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | Cei | rtificate of L | Death | | Reg. No. 2 | 2 0 995 |
| ı | Physicia Media | | SOLOMON | REDDICE | ζ | | | 2. Date of De Month Februa i | Day Yes | 3. Time of Death 11:45 PM |
| 100 | Examir | | 4a. Facility Name (if not institution, give street Loch Raven Center | | ercare | 4b. City, Town, or Park | Location of De | | 4c. County of D | eath ore County |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. Ia | | If Under 1 Year Months Days | If Under 24 F | rs. 8. Date of Birlin. (Month, Da | th 9, | Birthplace (State or Foreign Country) |
| | Director | | Usual Residence of Decedent | 12□F 88 | Yrs. | | | Nov 3, | | rth Carolina |
| | aryland a-f sho fied at | ctor | 10a. State 10b. County Maryland N/A | | , Town or Lo | ore City | | | | 10d. Inside City Limits 1 X Yes 2 □ No |
| | the Ma a or 28 oe noti | E Dir | 10e. Street and Number | | JGI CIII | 10f. Zip Code | | | 10g. Citizen of What | |
| | ath with | Funeral Director | 722 E. Belverdere A | | 110 1 | | 1212 | /Cif- VN- | USA | |
| 980 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | ٥ | 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced | Was Decedent Ever in U.S. Armed Forces? 43-1 1 XI Yes 2 No If Yes, Give Year or Dates. | 45 45 | f Yes, specify Cuba | n, Mexican, Pu | (Specify Yes or No- erto Rican, etc.) | Black, W | merican Indian, hite, etc. rican America: |
| 15-0 | 2 hour ''natu | Completed | 15. Decedent's Educa (Specify only highest grade of | tion | 16a. Deced | dent's Usual Occupa | ation Juring most of v | vorkina | 16b. Kind of Busine | |
| 212 | within 7 giene. er than , the M | | Elementary/Secondary (0-12) | College (1-4 or 5+) | | O NOT use retired) ${\sf rney} {\sf at} { m L}$ | aw | Ü | Lega1 | |
| Baltimore, Maryland 21215-0036 | d 2 should be filed within 72 saith and Mental Hygiene. n 27 is marked other than ", er traumatic event, the Med | To Be | 17. Father's Name (First, Middle, Last) Hezekiah Red | ldick | _ | | 18. Mother's N | Name (First, Middle, 3 | Maiden Sumame) Wa1ker | |
| Man | 2 shoule th and P 17 is ma trauma | | 19a. Informant's Name/Relationship (Type, I | | | | | | r, City or Town, State, | zip Code) 90035 s Angeles, CA |
| re, l | 1 and 5 of Healt fitem 2 | | 20a. Method of Disposition | 50n) 20b. Pi | lace of Dispo | sition (Name of | | Date Date | 20c. Location - City | |
| timo | tt. Page rtment rtant: li rjury or | | 1 🐰 Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify) | noval from State Dul | | y Mem Gro | | 23/2012 | Timonium, | Maryland |
| Ba | permi Depar Impor any ir | | Martin D. Lawson | | | | | | AL HOME I e, Marylan | NC d 21212 |
| | Dhastatoor | | 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca Immediate Cause (Final | luse on each line. | | | g, such as cardi | iac or respiratory arr | est, | Approximate Interval Between Onset and Death |
| ا ا | Physician/ Medical | | disease or condition resulting in death) | ADVANCED I | | 1.A | | | | S. S. S. S. S. S. S. S. S. S. S. S. S. S |
| | Examiner | er | Sequentially hat our ditione, if any, leading to immediate cause. Enter Underlying | FAILURE TO | | VE | | | | |
| K | uted Id ransit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | Dac to for as a consequ | erice oi). | | | | | |
| 0 | cate be executed physician and s the burial-transit | cal Ex | resulting in death) Last | Due to (or as a consequent | ence of): | | | | | |
| 8760 | ificate ling bhys | Medical | IF FEMALE: | | | | - | | | |
| P.O. Box 68 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi | Physician/M | 23b. Was decedent pregnant in the past 12 months? | If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown | death 3 | Ectopic pregnancy Other (specify) | <i>y</i> | | 23d. Date of Month | delivery Day Year |
| s, P.O | res that the signed by | by | Part II. Other significant conditions contrib Coronary artery dis | | | | | | | to the cause of death? Probably 4 X Unknown |
| ord | w requii s been 2 should | Completed | Chronic Kidney Dise | ease | | | | 24a. Was a | an 24b. Were | autopsy findings available |
| Rec | : The lar cate ha | | | | | | | autop perfor | med? death | o completion of cause of ? /es 2 🏋 No |
| Vital | /sician: s certifi director | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hosp | ital: | - P/Outpation | Otho | r: V Number | | | |
| n of | ding Phy th. After this funeral o | | 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation | | 28b. Time of injury | 28c. Injury work? | at | _ | ence 6 Other (Sp ow injury occurred | ecity) |
| Division of Vital Records, | I or Atten after dea Director: J in by the | Certificate: | 3 Suicide 6 Could not be | 8e. Place of Injury - At hor building, etc. (Specify) | ne, farm, stre | | 103 2 110 | 28f. Location (Si City or Town | treet and Number or F n, State) | Rural Route Number, |
| | e Hospita 24 hours e Funeral | Medical | 29a. Certifier (Check 2 Medical Examiner: only one) 3 Certifying Nurse Pro | a: To the best of my knowle | and/or investi | igation, in my opinior | death occurre | d at the time date an | nd place and due to th | e cause(s) and manner stated |
| | To th Withir Comp. | < | 29b. Signature and title of certifier | PHYSICIAN | | 29c. License | number | | 29d. Date signed (Mor | nth, Day, Year) |
| | 10 | | 30. Name and address of person who compl | | | D0068 | 3454 | | 02,21 | , 2012 |
| | 10 | | Pamela Aung, MD, 87 | 710 Emge Road | l, Par | kville, M | iaryland | 1 21234 | | |
| | Stat Registra | | FEB 2 2 2012 | 32. Regiotrar's Signatu | Red . | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ _Month 2045 0 m 4 5 Ward eh 20 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Howard County General Hospital** Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min nth, Day, Year) Mar 24, 1940 212-42-3463 71 **Director** 1 M 2 - F MD Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland at 10c. Citv. Town or Location 10d. Inside City Limits Director must be notified. MD Howard West Friendship 1 🗆 Yes 2 🔊 No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 12562 Clover Hill Dr. 21794 U.S.A. "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death 10 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Business Owner** Produce 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward George Rahll Sr. Madelyn Bittner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Rahll 12562 Clover Hill Dr. West Friendship, MD 21794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Atlantic Crematory, LLC Feb 21, 2012 Glen Burnie, MD 4 Donation 5 Other (Specify) Silmature of Funeral Servi 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each line o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician. **Medical** Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy after death.

Director: After this certificate | Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examine? Hospita 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Mann Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 0027717

State Registrar Willie W.

FEB 2 2

Columbia, MD, 20772

5755 Cedra Lane.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Bivings Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1000 TIMBOD 42 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours 76 1 🗷 M 2 🗆 F Director 213-32-4790 Oct. 29, 1935 Maryland Usual Residence of Deceden 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits Oa. State **Funeral Director** injury or other traumatic event, the Medical Examiner must be notified 1 Yes 2 X No Windsor Hills MD Baltimore ò 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a 21244 U.S.A 2815 Ridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. by 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married and 2 should be filed within 72 hours after of Health and Mental Hygiene.

tem 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify Specify 3 X Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Union Iron Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wilbur Ε. Roberts Ivory Virginia Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Roberts 5517 Weywood Drive Reisterstown, MD tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lake View Mem. Park 2/21/12 Sykesville, MD 22. Name and Address of Facility ELINE FUNERAL HOME ture of Funeral Service Licensee Wayne Osterling 11824 Reisterstown Road Reisterstown, MD 21136 23a. Part 1. Enter the disease, or shock, or heart fallure. List or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ptiL Sh Medical **Examiner** enmon Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Die to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): at ending physician Ifcruse as the buria Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23d, Date of delivery 23b. Was decedent pregnant es, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) Box in the past 12 months?

1 Yes 2 No Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🖎 No 1 Dalient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

M DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AIRHAVEN KESVILLE CARROLL cial Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F 97 Min WASHING-TON 12 Director 611 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits must be notified at Director MV CARROLL YKESVILLE 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral er than "natural", or items 23a the Medical Examiner must by HIRN 21784 Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ₩ Widowed 4 □ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PIKESUILLE MD 21208-1095 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) ARNOIL CREM 2/20/2012 WINFIELD, MD 22. Name and Address of Facility N ZUMRWW I-H ENNOY CO SOUTH CARROLL CREM 21. Signature of Funeral Service Licensee

22. Name and Address of Facility, N 2UM KWW
6027 STEESULE ND ELOE

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. STRESVILLERY ELDERSBURGMO 21784 Approximate Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or a a consequence of): Examiner tension Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 burusr after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burus completed filled in by the funeral director, page 2 should be detached for use as the burus. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

FEB 2-2 2012

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death RUSZKIEWICZ Physician/ 5:00 AM 2012 FEBRUARY Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITAL HARBOR If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Social Security Number **Funeral Director** 1 □ M 2 💢 F 90 213-18-1357 Yrs. 09/08/1921 Maryland Usual Residence of Deced 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County should be filed within 72 hours after death with the Maryland Director must be notified 1 Yes 2 No Baltimore Maryland N/A 10f. Zip Code 10g. Citizen of What Country? ō 10e, Street and Number Funeral 23a United States 426 Cornwall Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force ō. ģ 1 Never Married 2 Married 2 **X**No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Completed 3 ▼ Widowed 4 □ Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Domestic 8 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I မ Agnes Czerniak Anthony Wisniewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 other tra 426 Cornwall Street Baltimore, Maryland 21224 Debbie Ruszkiewicz - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of h Important: If ite any injury or otl 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 02/21/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Dayld J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 21. Signa are f Funeral Service Lio nsee or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is only one cause on each line. Part 1. Enter the disease, shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final COLON CANCER Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Yes 1 Marient 2 ER/Outpatient 3 DOA ြု 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending Accident 1 Yes 2 🗌 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011

State

dress of person who completed cause of death (Item 23a) (Type, Print)

3001

5 32. Registrar's Signature

MATRIANO

29c. License number

HANOVER ST BALTIMORE MO 21225

29d. Date signed (Month. Dav. Year)

18 2012

FEBRUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05000 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Pb ROSE RECKSEIT 12:05 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death VANTAGE ITPHSE COLUMBIA HOWAR D Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth Birthpia. Country) NY 9. Birthplace (State or Foreign 1 □ M 2 🎇 F Months Days 07/25/1909 Director 064-03-0824 102 Yrs. Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🛛 No HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5400 VANTAGE POINT ROAD, #213 21044 USA . Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. tant; If item 27 is marked other than "natural", or items jury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 X Widowed 4 Divorced Completed Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LEGAL SECRETARY LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ PHILIP ZOLIN MOLLIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13821 JARRETTSVILLE PIKE, PHOENIX, MD 21131 JEFF RECKSEIT / SON 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WELLWOOD CEMETERY 02/21/2012 PINELAWN, NY 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CONCESTIVE HEMRT FAILURE Onset and Death Physician) 3 mo1/2 Medical resulting in death) Due to (or s a consequence of) Examiner ANEMIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami ATRIAL FIBRILLATION The law requires that the death certificate be executed month Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery 1 Live Birth 2 Live Fetal 300.4 Pregnant at time of death 9 Unknown in the past 12 months?
1 Yes 2 No Year Month Day the ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, been si Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 🗌 Yes 2 🗌 No Yes 2 William Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 W No 1 Yes Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1/05P11 € After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No 24 hours after death. Funeral Director; A 2 Accident
3 Suicide completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chlasic 14P Feb 20, 2012

DHMH 17 Rev 7/2009

State Registrar , Cilumsia MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
11055 Lime PahixentPhiny Switt 103

31. Date filed (Month, Day, Year)